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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF WYOMING

FILED

4:37 pm, 12/22/20

Margaret Botkins
Clerk of Court

CARLEY CLAUSEN, Plaintiff, vs. EASTERN SHOSHONE TRIBE HEALTH CARE PLAN, EASTERN SHOSHONE TRIBE, FIRST NATION , aka FIRST NATION HEALTHCARE, LLC, Defendants.	)	Civil No. 20-CV-242-F

COMPLAINT

COMES NOW the Plaintiff, Carley Clausen, and for her Complaint against the Eastern Shoshone Tribe Health Care Plan ("Plan"), the Eastern Shoshone Tribe ("EST") and FirstNation Health ("FirstNation"), alleges and states as follows:

INTRODUCTION

1. Plaintiff files this action for declaratory relief, recovery of benefits due and to enforce her rights as a participant in a group employee welfare benefit plan pursuant to the Employee Retirement Income Security Act ("ERISA") 29 U.S.C. § 1001, *et. seq.*, to enforce her statutory rights under ERISA and to recover damages under the laws of the State of Wyoming.[1]

2. Plaintiff's claims are based on the failure of the Defendants to make payments to medical providers on allowed claims in excess of $250,000.00 as required under the terms of the Plan sponsored by EST and administered by FirstNation and on the false representations by FirstNation that the claims have been properly adjusted and paid, which wrongful acts have caused, and will continue to cause, actual damages to Plaintiff.

JURISDICTION AND VENUE

3. **Subject Matter Jurisdiction.** This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331 because this is a civil action arising under the laws of the United States and pursuant to 29 U.S.C. §§ 1132(e)(1), 29 U.S.C. § 1132(e)(2) and 29 U.S.C. § 1132(f).

[1] On November 27, 2018, Plaintiff filed suit against EST and FirstNation in the Wind River Tribal Court, Fort Washakie, Wyoming raising some, but not all, of the claims made in this Complaint. The case was subsequently stayed by stipulation of the parties and was ultimately voluntarily dismissed without prejudice by Plaintiff on April 30, 2019. The claims have not been resolved and Plaintiff now seeks relief herein.

4. **Personal Jurisdiction.** This Court has personal jurisdiction over all Defendants. 29 U.S.C. § 1132(f). All Defendants are residents of the United States and the Court therefore has jurisdiction over them. The Court also has personal jurisdiction over FirstNation pursuant to Fed. R. Civ. P. 4(k)(1)(A) because FirstNation transacts business in this District and has significant contacts with this District.

5. **ERISA.** Plaintiff is entitled to maintain an ERISA action pursuant to ERISA §§ 502(a)(1)(A) and (B), 29 U.S.C. §§1132(a)(1)(A) and (B); ERISA 502(a)(2), 29 U.S.C. §§ 1132(a)(2); ERISA 502(c)(1) and (3), 29 U.S.C. §§ 1132(c)(1) and 1132(3).

6. **Venue**. Venue is proper in this District pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2) because the Plan is administered in this District and the violations of ERISA took place in this District and pursuant to 28 § U.S.C. 1391 because all Defendants are located in this District or continuously do business in this District and because the events and omissions giving rise to the claims asserted herein occurred within this District.

PARTIES

7. Plaintiff is a resident of Riverton, Wyoming. Plaintiff is not an enrolled member of any Tribe and is not entitled to receive medical benefits or other health care services provided to Native American people by Indian Health Services or otherwise.

9. EST is a federally recognized Tribe of the Wind River Reservation, Wyoming

10. First Nation, aka First Nation Healthcare, LLC is an Oklahoma Limited Liability company providing health benefits consulting and management. It is licensed

Third Party Administrator and brokerage firm, which, according to its public information, "offers a full menu of services including claims administration, plan design, PPO structure, compliance, COBRA administration, reinsurance, untilization review/case management" and provides services to meet the needs of the "Native American business community to better understand the complex financial angles of a Healthcare Benefit Plan." FirstNation is not qualified to do business in Wyoming nor is it licensed by Wyoming to serve either as an insurance broker or producer nor as a fiduciary or administrator of ERISA health benefit plans in Wyoming.

STATEMENT OF FACTS COMMON TO ALL CLAIMS

The Benefit Plan.

11. In 2012, EST established and thereafter maintained an employee welfare benefit plan ("Plan") for employees of EST for the purpose of providing subscribers and beneficiaries medical insurance coverage. EST is the plan sponsor within the meaning of ERISA § 3(16)(B), 29 U.S.C. § 1002(16)(B).

12. At all times relevant herein, the Plan meets the definition of an "employee welfare benefit plan" under ERISA, 29 U.S.C. § 1002(1), because it is a plan, fund, or program which was established or maintained by an employer for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits. *See, also, Donovan v. Dillingham*, 688 F.2d 1367 (11th Circ. 1982).

13. Defendants have, in some instances, claimed that the Plan is a governmental plan within the meaning of 29 U.S.C. § 1002(32) and thus exempted from ERISA coverage under 29 U.S.C. § 1003(b)(1), but have nevertheless always

represented to Plan participants and beneficiaries that the Plan is operated in compliance with ERISA requirements. Moreover, no version of the Plan relevant here is a governmental plan within the meaning of 29 U.S.C. § 1002(32) such that the Plan is exempt pursuant to 29 U.S.C. § 1003(b)(1).

14. From August 20, 2013, to May 22, 2018, Plaintiff was employed by EST as a Registered Nurse for Morning Star Care Center ("Morning Star"), a nursing home licensed by the State of Wyoming and owned and operated by EST. EST owns and operates Morning Star on a commercial basis and patients are accepted and employees hired without regard to tribal affiliation.

15. When Plaintiff began employment at Morning Star, a document was provided to Plaintiff by her employer which was represented by her employer as setting out the terms and conditions of the Plan established by EST for the benefit of its employees. (Exhibit 1 the "Plan").

16. During her employment, Plaintiff was a participant/beneficiary of the Plan and paid for the coverage in accordance with Plan requirements. She continued coverage for several months through COBRA coverage after her employment ended. At all times relevant herein, Plaintiff was a participant within the meaning of ERISA § 3(7), 29 U.S.C. §1002(7). She has a colorable claim to benefits under the Plan and she has performed all of the required conditions to be eligible for payment of medical insurance benefits under the Plan.

17. In 2014, Plaintiff was informed by her employer that EST had changed the Plan administrator and was also told that the Plan was not changed. In approximately August of 2014, Plaintiff was provided with a UNUM brochure, *see*, Exhibit 2 UNUM

brochure, describing the medical benefits available to employees. *Id, at 4.* The medical benefits are unchanged from the benefits described in the 2012 document.

18. After reviewing the UNUM brochure, Plaintiff reasonably understood and believed that her medical benefits, including the deductible, coinsurance, office visits, emergency medical care, prescription coverage vision and dental benefits, as well as disability benefits remained as set forth in the 2012 Plan document.

19. From 2012 through 2016, Plaintiff had occasion to file claims for benefits under the Plan, and the claims were routinely covered and paid as described in the 2012 Plan document.

Fiduciary Status.

20. Every ERISA plan must have one or more "named fiduciaries." ERISA § 402(a)(1), 29 U.S.C. § 1102(a)(1). The "administrator" in the plan instrument is by definition a named fiduciary and, in the absence of such a designation, the sponsor is the administrator. ERISA § 3(16)(A), 29 U.S.C. §1002(16)(A).

21. The Plan provides that EST is the sponsor, the named fiduciary and the Plan Administrator. In addition, the Plan specifically provides that the Plan Administrator, "or its delegate has the sole authority and discretion to interpret and construe the terms of the Plan, including but not limited to, eligibility under the Plan, payment of benefits or claims under the Plan..." At all times relevant herein, FirstNation was delegated by EST to make decisions as to payment of benefits under the Plan and did in fact make determinations concerning payment of benefits under the Plan.

22. ERISA treats as fiduciaries not only persons explicitly named as fiduciaries under § 402(a)(1), 29 U.S.C. § 1102(a)(1), but also any other persons who in

fact perform fiduciary functions. ERISA § 3(21)(A)(i), 29 U.S.C. § 1002(21)(A)(i). Under applicable standards, both EST and First Nation are fiduciaries.

Plaintiff's claims for medical benefits.

23. In November 2017, Plaintiff was scheduled for endoscopic sinus surgery at the Casper Surgical Center in Casper, Wyoming. Prior to the surgery, Plaintiff and her surgeon Dr. Caleb Wilson with Wyoming Otolaryngology sought preauthorization for the procedure as required under the Plan terms. The surgery was approved and was subsequently performed.

24. On February 15, 2018, Plaintiff required emergent care for a heart attack she suffered at her place of work, the Morning Star, in Fort Washakie. Plaintiff was transferred from Morning Star to the Sage West Hospital in Lander via ground ambulance. Plaintiff was later transferred from Lander via ground ambulance to the airport in Riverton, Wyoming. From there, Plaintiff was transferred by air ambulance to Wyoming Medical Center in Casper, Wyoming, where she received care for an acute MI of the inferior wall via percutaneous transluminal angioplasty of the coronary artery and had a drug eluting stent placed.

25. On subsequent occasions during 2018 Plaintiff presented for treatment at the emergency room at Sage West Hospital in Riverton, Wyoming for related heart events. On two later occasions in 2018, Plaintiff was also seen and admitted to the Wyoming Medical Center for treatment of her heart condition.

26. Pursuant to the Plan requirements, the providers of the medical services described in Paragraphs 23, 24 and 25, above, properly submitted claims for payment to the Plan.

27. Thereafter, consistent with Plaintiff's previous experience, she began receiving Explanation of Benefits Forms detailing the amounts paid to her providers and the balances which she owed. Exhibit 3 (examples of "EOB" or ("EOBs")).

28. The EOBs which Plaintiff received relating to the treatments described above did not indicate that any of the claims were denied nor did the EOBs provide any notice or information concerning any right to request a review of coverage or payment decisions.

29. In reliance upon the terms of the Plan and the EOB forms she received, Plaintiff undertook to pay her medical providers the amounts indicated by the EOBs as her portion of the bills.

30. Plaintiff reasonably relied upon the terms of the Plan and the EOBs and believed that the claims submitted by her medical providers would be, and were, processed and paid in accordance with the Plan's terms and the representations made in the EOBs.

Plaintiff's discovery that the medical claims were not being paid.

31. In July, 2018, Plaintiff began receiving bill collection notices for the costs of medical services, and so learned for the first time that the Plan was not paying medical claims as required under the Plan and as represented in the EOBs.

32. Plaintiff contacted Ina Weed-Hurley, Human Resource Specialist at Morning Star for an explanation of why the medical claims were not being paid as represented in the EOBs and required under the Plan. Together, on July 24, 2018, Plaintiff and Ms. Hurley placed a call to Matt Silverstein, the Chairman and CEO of FirstNation.

33. Mr. Silverstein explained to Plaintiff that there was a disagreement with the Plan's previous Third Party Administrator concerning correct payment amounts but he assured Plaintiff that the providers' claims were being processed and that the payments due under the Plan would be paid within 30 days.

34. On July 25, 2018, Plaintiff received a message from Ms. Hurley, documenting the previous day's conversation. In the message, Ms. Hurley reiterated the explanation and assurances given to Plaintiff by Mr. Silverstein:

> He stated that the TPO Network was not repricing claims correctly and this is holding up the review process for bills getting paid, which once that is configured those bills will be taken care.
>
> * * *
>
> Sage West medial bills - this has a Global Settlement that will be concluded in 30 days.[2]
>
> Guardian Flight - will be writing off the bill that you have been waiting for but now answers why you did not receive one. You will also receive a EOB (Explanation of Benefits) concerning this write off. -good news-[3]
>
> Exhibit 4.[4]

FirstNation's admission that Plaintiff's claims should have been processed and false assurances that the claims had been, or would be, paid.

35. Despite Mr. Siverstein's promises, Plaintiff continued to receive invoices and collection notices from her medical providers, and therefore in August 2018, she sought the assistance of counsel. On August 15, 2018, counsel for Plaintiff wrote to FirstNation requesting confirmation that Plaintiff's outstanding invoices would be paid by August 25, 2018. Exhibit 5.

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[2] To the best of Plaintiff's knowledge and belief, there has been no settlement and the full Sage West medical bills are still due and owing.

[3] To the best of Plaintiff's knowledge, there are four Guardian Flight [an air ambulance provider] bills; none were paid or written off. The ground transportation from Casper Airport to the hospital was paid to best of Plaintiff's knowledge.

[4] This email address was used by the Plaintiff in July, 2018.

36. On August 27, 2018, FirstNation's counsel, Jack Freese, responded by letter, stating that:

> *At this time there is a dispute between the Tribe and the PPO Network and FirstNation on the discount of the original billed charges For several providers, including some of Ms. Clausen's, First Health PPO Network [5] was continuing to send the Tribe claims that were priced at an old discount and not as agreed. First, please be assured that FirstNation is working diligently with the indicated parties to resolve the issues and to expedite the crediting, processing and appropriate resolution of all claims including Ms. Clausen, which should have earlier occurred without delay or disruption. Some of Ms. Clausen's claims have reportedly been processed and paid. After this week's check run, the only outstanding claims for Ms. Clausen will be the one at Sage West and all parties described above are actively working to remedy the issues.*
>
> *Simply stated, FirstNation was not the source of the problem and is trying diligently to resolve things in the best interest of the Tribe, tribal members and its employees.*

See, Exhibit 6. Letter from John M. Freese, Sr., Freese & March, PA

37. Although Mr. Freese represented to Plaintiff that her providers were not being paid because First Health had been approving claims at "*an old discount rate and not as agreed,*" on information and belief Plaintiff asserts that First Health was correctly processing and submitting claims for payment in compliance with existing discount rates and that EST, at the direction of FirstNation, was refusing to make payments to Plaintiff's medical providers as required by the terms of the Plan and the existing agreements with providers.

38. Despite the assurances and promises from FirstNation, almost none of Plaintiff's benefits' claims, properly payable under the Plan, for medical services from

[5] The reference to "the PPO Network" is a reference to First Health, a national PPO network, wholly owned by Aetna Insurance Company. On information and belief, First Health was the Plan's Third-Party Administrator prior to September 1, 2017.

and after November 2017, have been paid to date, and Plaintiff's medical providers are seeking payments from her of amounts in excess of $250,000.00.

Why Plaintiff's medical claims were not paid.

39. On information and belief, sometime prior to September 1, 2017, FirstNation was employed by EST as a consultant on health benefits matters. In its role as consultant, FirstNation represented to EST that the discount rates negotiated by First Health were much lower than normative in the health care industry. *See*, e.g. Exhibit 7, EST press release Dec. 21, 2018. FirstNation represented to EST that it could obtain greater discounts for the Plan than had been obtained by First Health.[6] *See,* Exhibit 4 and 6.

40. On information and belief, FirstNation caused EST to replace First Health with FirstNation as the Plan's Third Party Administrator on September 1, 2017.

41. On information and belief, after September 1, 2017, FirstNation delayed processing some claims and/or advised EST to entirely withhold payment of some claims under the Plan based on FirstNation's assurances to EST that it would negotiate larger discounts with medical providers, thereby reducing the amount that the Plan would be required to pay to the providers.

42. On information and belief, FirstNation did not successfully negotiate the discounted rates that it promised to obtain but, sometime in early 2018, began falsely representing that new, more substantial discounts had been negotiated. FirstNation relied on this false representation to assure Plaintiff that it was "working diligently . . . to

[6] Typically, a benefits plan or insurance company, often through a third-party administrator, negotiates agreements with medical providers to reduce the amount billed by a percentage so that the amount actually accepted in full payment for a medical service is substantially less than the amount billed. Since each such payor negotiates its particular discount, the amount of discount may differ widely from one benefits plan/administrator to another.

resolve the issues and to expedite the crediting, processing and appropriate resolution" of her claims. *See*, Exhibit 6.

43. On information and belief, at the same time it was delaying the processing and payment of benefits claims, FirstNation refused to process or approve claims under the existing discount rates negotiated and previously paid by First Health pursuant to the Plan terms.

44. On information and belief, FirstNation developed and implemented a practice of reviewing claims and issuing EOBs purporting to allow claims on the basis of new discount rates negotiated by First Health and/or FirstNation when in fact no such rates had been negotiated.

45. On information and belief, in 2018, FirstNation issued some EOBs to Plaintiff falsely showing that her claims were being processed and paid "according to the First Health Network agreement" *See*, as examples, Exhibit 3 EOB forms. It issued additonal EOBs falsely indicating that her claims had been processed and "allowed at 150% of the Medicare or Medicare equivalent rate." *See*, as examples, Exhibit 3 EOB forms - Medicare. In fact, the alleged payments have never been made to the providers, who are now seeking full payment from Plaintiff. *See* Exhibit 8.

46. Contrary to the assertions made by FirstNation, the representations made by FirstNation and contained in the EOBs issued to Plaintiff are substantially false and materially misleading in that a) the documents purport to reflect payments made to providers when, in fact, the payments have not been made; b) the documents purport to reflect that the payments were made pursuant to a new rate negotiated by First Health, the Third-Party Administrator prior to FirstNation, even when there was no such

negotiated rate and no minimal responsibility for payments to her providers, when, in fact, the amounts her providers are seeking from Plaintiff because of non-payment by the Plan is in excess of $250,000.00.

47. In an attempt to determine the basis for the representation by FirstNation that her providers' claims have been paid in accordance with existing agreements, Plaintiff submitted a request for information pursuant to ERISA § 502(c)(1), 29 U.S.C. §1132(c) to both EST and FirstNation. *See* Exhibit 9 (dated November 7, 2019). The letter was received by EST on November 18, 2019 and by FirstNation on November 15, 2019. *See* Exhibit 10. As of the date of filing, Plaintiff has received no reponse.

FirstNation's method of processing benefits' claims.

48. On information and belief, FirstNation, acting as the delegated Plan Administrator and as a *de facto* Fiduciary, has knowingly and intentionally put in place a pattern and practice whereby it does not negotiate or attempt to negotiate discount rates with providers for medical services to individuals who are not eligible for Indian Health Services ("non-eligible individuals").

49. On information and belief, as a matter of policy and practice and in violation of the terms of the Plan, FirstNation routinely knowingly and intentionally fails and refuses to review, adjust or pay claims made for services to certain non-eligible individuals, including Plaintiff. Instead, as a matter of policy and practice, FirstNation advises non-eligible individuals, including Plaintiff, to wait until medical bills are turned for collection, and to then contact FirstNation, at which time, according to FirstNation, it will attempt to negotiate a settlement with the collection agency.

50. Consistent with its policy and practice, FirstNation has failed and refused to review, process and approve the claims for services to Plaintiff under the Plan in accordance with existing negotiated rates with various providers. Instead, FirstNation continues to falsely assert that Plaintiff's claims have been properly handled and paid in compliance with the Plan, with full knowledge that its representations are false.

Plaintiff is entitled to have her claims for medical benefits paid.

51. As set out in the preceding paragraphs, claims were properly submitted to the Plan by Plaintiff's medical providers for payment of amounts due for services provided to Plaintiff pursuant to the Plan.

52. Plaintiff fulfilled all requirements for the payment of medical benefits under the Plan, including paying her annual deductible and out-of-pocket amounts.

53. The medical services provided to Plaintiff for which no payments have been made are covered under the Plan and are eligible for payment.

54. Neither EST nor FirstNation, acting on behalf of the Plan, have denied coverage of any of Plaintiff's medical service claims, and have, to the contrary, issued EOBs showing that the claims have been allowed and paid.

55. The medical claims have not been paid as indicated by the EOBs. This continuing failure and refusal by EST and FirstNation, acting for the Plan, to pay these approved claims amounts to a wrongful denial of benefits under the Plan.

56. Because Plantiff's claims for benefits were not denied, but instead have been falsely alleged by Defendants to have been paid, she has no administrative appeals process available to her. She has exhausted the available direct contacts with

Defendants, to no avail, since they continue to assert that the claims have been paid even though that assertion is false.

57. In purporting to pay the claims submitted by Plaintiff's medical providers and issuing false EOBs showing the claims to have been paid and also showing that Plaintiff is not responsible for payment of addition amounts or for only minimal amounts, EST and FirstNation knowingly and intentionally deceived Plaintiff to her detriment.

58. In purporting to pay the valid claims payable under the Plan and issuing false EOBs showing the claims to have been paid, EST and FirstNation knowingly and intentionally violated the Plan terms and breached the contract with Plaintiff created by the Plan to Plaintiff's detriment.

59. In purporting to pay the valid claims for which payment is due under the Plan and in issuing false EOBs showing the claims to have been paid, EST and FirstNation knowingly and intentionally violated the terms and provisions of ERISA.

60. Plaintiff has been damaged by the harmful and illegal acts of EST and FirstNation and the harm and damages include, but are not limited to the following:

60.1 Plaintiff has received and continues to receive telephone calls and written notices seeking payment from her for the medical services which the Plan is obligated to pay.

60.2 In addition to her heart condition which requires ongoing monitoring, Plaintiff has Type 1 Diabetes and requires medical services and supplies for her health conditions. Because of Defendants' failure and refusal to actually pay the allowed claims for medical services in keeping with Plan requirements, Plaintiff suffers from concern and fear that her providers may to refuse to treat her conditions and that the lack of medical treatment will lead to further medical complications, causing her severe emotional distress and potentially worsening her health status.

60.3 Because of the failure and refusal by EST and FirstNation to pay the claims which FirstNation acknowledges are valid, Plaintiff is now refused medical services by a number of her providers, including

Wyoming Cardiopulminary, Casper Surgical Center and Wyoming Otolaryngology. As a result, Plaintiff is unable to receive necessary ongoing treatment from the medical providers who are familiar with her condition and upon whom she has reasonably come to depend for medical care. Additionally, because the number of specialized medical providers in Wyoming is limited, Plaintiff is now required to travel significant distances out-of-state to obtain medical care. In some instances she has been unable to find medical providers for the critical care that she requires because her credit report reflects unpaid medical bills and new providers decline to accept her as a patient.

60.4 Because Plaintiff's credit reports reflects unpaid medical bills, her credit score has been reduced to the point that she cannot obtain credit cards, she has been denied loans for purchase of a vehicle and has been required to pay an increased interest rate to obtain and maintain financing for her home.

60.5 All of the above-described consequences were suffered as a result of the knowing and intentional failure of Defendants to comply with the terms of the Plan, the requirements of ERISA and their contractual obligations have caused Plaintiff serious and ongoing emotional distress and direct financial loss.

60.6 As a result of the knowing, intentional and wrongful actions of EST and FirstNation as alleged herein, Plaintiff is entitled to relief.

FIRST CAUSE OF ACTION -
DECLARATORY JUDGMENT AS TO NATURE OF PLAN

61. Plaintiff seeks equitable relief pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), and hereby re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

62. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action to obtain "appropriate equitable relief ... to enforce any provisions of this title." Pursuant to this provision, 28 U.S.C. §§ 2201 and 2202, and Federal Rule of Civil Procedure 57, Plaintiff seeks declaratory relief that the Plan is not a Governmental Plan within the meaning of ERISA § 3(32), 29 U.S.C. § 1002(32), and thus it is subject to the provisions of Title I and Title IV of ERISA.

SECOND CAUSE OF ACTION – PAYMENT OF BENEFITS

63. Plaintiff hereby re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

64. Plaintiff seeks a declaration pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) and ERISA § 503, 29 U.S.C. § 1133 that the Plan, EST and FirstNation acting individually or in concert as Plan Administrators and Fiduciaries, have wrongly failed and refused to pay benefits due as required by the Plan and have wrongly issued false EOBs.

65. Plaintiff seeks an order requiring the Plan to pay all amounts owing to Plaintiff's medical providers for services to her during 2017 and 2018.

THIRD CAUSE OF ACTION - BREACH OF FIDUCIARY DUTY

66. Plaintiff seeks equitable relief pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), and hereby re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

67. EST is the named fiduciary under the Plan, and FirstNation is a *de facto* fiduciary under the Plan under 29 U.S.C. § 1102(a)(2), 29 U.S.C. § 1102(21)(a).

68. Each Defendant breached its fiduciary duties including, by way of example and not with limitation: failing to itself or through delegation, ensure that claims were reviewed appropriately, by failing to ensure that FirstNation had in fact negotiated the discount rates that it claimed to have obtained; by failing to ensure that claims were paid pursuant to existing negotiated rates; by failing to ensure that accurate and truthful EOBs were issued; and, by failing to ensure that allowed claims were timely paid

pursuant to the Plan once a participant met the required annual deductible and out-of-pocket amounts.

69. The failure of EST and FirstNation to meet their fiduciary obligations and to enforce the provisions of ERISA have resulted in harm to Plaintiff.

FOURTH CAUSE OF ACTION –
BAD FAITH DENIAL OF INSURANCE BENEFITS - DEFENDANT FIRSTNATION

70. Plaintiff re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

71. It is undisputed that at all time relevant herein Plaintiff was a participant in the Plan and eligible for medical benefits pursuant to the Plan.

72. It is undisputed that FirstNation, with delegated authority and/or as Third Party Administrator, determined that the claims at issue in this matter are allowable and covered under the terms of the Plan.

73. EOBs were issued for the claims in this matter evidencing that the claims were covered, allowed and paid and that Plaintiff owed either no amount or a minimal amount to each provider after payment by the Plan.

74. The payments purported by FirstNation to have been paid have in fact not been paid.

75. FirstNation has failed and refused to process and pay Plaintiff's medical claims despite its own determination that Plaintiff is entitled to coverage under the Plan and that the medical claims are allowable and eligible for payment pursuant to the Plan.

76. FirstNation has acted with knowledge of, or in reckless disregard of, the absence of any reasonable basis to withhold payment of benefits. The action amounts to gross abuse and intentional tortious conduct.

77. The failures and actions of FirstNation in failing to authorize the payments it approved and in issuing false EOBs showing the payments to have been made constitutes an intentional breach of contract and bad faith.

FIFTH CAUSE OF ACTION
VIOLATION OF COVENANT OF GOOD FAITH AND FAIR DEALING - FIRSTNATION

78. Plaintiff re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

79. Every contract includes an implied covenant of good faith and fair dealing. The implied covenant of good faith and fair dealing requires that neither party commit an act that injures the rights of the other party to receive the benefit of the agreement. Compliance with the obligation to perform a contract in good faith requires that a party's actions be consistent with the agreed common purpose and justified expectations of the other party. A breach of the covenant of good faith and fair dealing occurs when a party interferes or fails to cooperate in the other party's performance.

80. FirstNation has violated and continues to violate the covenant of good faith and fair dealing in one or more ways, including the violations set out in the preceding Paragraphs of this complaint as more particularly described in Paragraphs 81 through 85.

81. FirstNation knowingly and intentionally falsely represented to Plaintiff that it had negotiated discount rates with her providers and that it had, or would, fully pay medical benefits according to the negotiated rates.

82. FirstNation knowingly and intentionally with an intent to deceive issued EOBs to Plaintiff falsely reciting that the medical claims had been paid and falsely

reciting that the balance due from Plaintiff was zero or a minimal amount, in a deliberate attempt to conceal the facts of non-payment.

83. FirstNation knowingly and intentionally has failed and refused to authorize payment for medical claims that it admits are proper and allowable under the Plan, thereby wrongfully depriving Plaintiff of medical benefits which FirstNation knew were provided for under the Plan.

84. FirstNation knowingly and intentionally adopted a practice of assuring participants, including Plaintiff, that medical benefits were being paid, when in fact the benefits were not being paid and then, when the non-payment was discovered, of explaining to participants that FirstNation would deal with the claims by negotiating payments with collection agencies. FirstNation thereby developed a pattern and practice of intentionally withholding payments due under the Plan until the claims are turned for collection, for the purpose of allowing for a reduced payment by way of negotiations with collection agencies.

85. FirstNation developed this pattern and practice of reducing the amount paid by the Plan for medical claims by waiting until the claims are submitted for collection, knowing that the practice would necessarily damage the participants' credit ratings and financial reputation and stability.

86. The breach of the covenant of good faith and fair dealing has caused Plaintiff severe emotional distress; has damaged her credit rating; has directly caused her to pay an increased interest rate on her home mortgage loan; caused her to be unable to obtain credit; including credit cards; has caused medical debt in excess of $250,000 to be turned over to collection for which Plaintiff is being billed for the original

cost and additional interest; and has resulted in her medical providers refusing to continue providing her with any medical services.

87. This failure to pay benefits and pay benefits without delay has caused injury to Plaintiff.

SIXTH CAUSE OF ACTION
FRAUD

88. Plaintiff re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

89. FirstNation represented to the participants of the Plan, including Plaintiff, that it reviewed, processed and paid claims for medical benefits arising under the Plan in accordance with the Plan's terms.

90. These representations made by FirstNation were false, FirstNation knew the representations to be false and made the representations with the intention to assure individuals, including Plaintiff, that medical insurance was a benefit available as part of compensation for employment, thereby providing an incentive for individuals, including Plaintiff, to accept and maintain employment with EST.

91. These false representations made by FirstNation were additionally intended to induce individuals, including Plaintiff, to participate in the Plan and to pay sums of money to the Plan in order to participate.

92. Plaintiff reasonably relied on the representations made by FirstNation that it reviewed, processed and paid medical claims in accordance with the Plan provisions and in reliance on those false representations, paid premiums for the Plan during her employment and paid for COBRA coverage after her employment ended.

93. Plaintiff has suffered economic loss and emotional distress as a direct and proximate result of the false representations made by FirstNation.

SEVENTH CAUSE OF ACTION
INFLICTION OF EMOTIONAL DISTRESS - FIRSTNATION

94. Plaintiff re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

95. As set forth in this Complaint, Defendant FirstNation has knowingly and intentionally breached its duties to Plaintiff, causing her extreme emotional distress.

96. Defendant FirstNation, through direct communications with Plaintiff, has actual knowledge of Plaintiff's specific health conditions, which are known to be worsened by emotional distress.

97. Defendant FirstNation, intentionally or with reckless disregard for the effects on Plaintiff, instituted and maintained its practice of a) failing to pay medical claims as required by the terms of the Plan and negotiated rates; b) deliberately waiting until claims are turned over for collection; c) to create an opportunity to negotiate a substantially discounted payment with collection agencies; d) for the specific purpose of allowing the Plan to avoid making the higher payments as required under the Plan; thereby causing Plaintiff extreme emotional distress and related physical damage.

EIGHTH CAUSE OF ACTION
EXEMPLARY DAMAGES

98. Plaintiff re-alleges and incorporates by reference all allegations in the preceding paragraphs of this Complaint.

99. FirstNation has acted with reckless disregard of the consequences of its actions under circumstances in which a reasonable person would know or have reason

to know that such conduct would, with a high degree of probability, result in harm to another.

100. FirstNation's past and continuing failure to pay benefits when due is a willful, wanton and intentional failure to honor the terms and covenants of the insurance contract. To be specific, EST and First Nation promised to make payments pursuant to the contract, intentionally failed and refused to make the payments due, are aware of the injuries caused to Plaintiff, and in spite of this knowledge continue to expose Plaintiff to significant liability, attorney fees, costs, judgments and emotional distress.

101. Defendant actions have directly, foreseeably and proximately caused and will continue to cause damage to Plaintiff.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays that judgment be entered against the Defendants on all claims and requests that the Court award the following relief:

A. Declare that the Plan is an employee benefit plan within the meaning of ERISA § 3(2), 29 U.S.C. § 1002(2) and that it is an employee welfare plan within the meaning of ERISA § 3(1), 29 U.S.C. § 1002(1); and that the Plan is not a Governmental Plan within the meaning of ERISA § 3(32), 29 U.S.C. § 1002(32).

B. Require EST and FirstNation to reform the Plan administration to bring it into compliance with ERISA;

C. Require EST and FirstNation to comply with ERISA reporting and disclosure requirements for the Plan, including if required by filing Form 5500 reports, distributing ERISA compliant Summary Plan Descriptions, Summary Annual Reports, and ERISA-compliant Participant Benefit Statements;

D. Appoint an Independent Fiduciary to manage and administer the Health Plan and its assets, and to enforce the terms of ERISA;

E. Order declaratory and injunctive relief as necessary and appropriate, including enjoining the Defendants from further violating the duties, responsibilities, and obligations imposed on them by ERISA with respect to the Plans;

F. Order Defendants to review, process and pay the benefit claims submitted for services provided to Plaintiff in full compliance with the Plan terms, including the provisions limiting Plaintiff's out of pocket and deductibles;

G. Award to Plaintiff attorneys' fees and expenses as provided by the common fund doctrine, ERISA § 502(g), 29 U.S.C. § 1132(g), and/or other applicable doctrines.

H. Award to Plaintiff taxable costs pursuant to ERISA § 502(g), 29 U.S.C. § 1132(g), 28 U.S.C. § 1920, and other applicable law.

I. Award to Plaintiff the penalty sum of $110 per day for failure of Defendants to provide the requested information under ERISA.

J. Award to Plaintiff pre-judgment interest on any amounts awarded pursuant to law.

K. Specifically require Defendants to reimburse Plaintiff for all medical expenses incurred during 2017 and 2018.

L. Award an amount to be proven at trial that will compensate Plaintiff for the severe and serious damage to her credit reputation caused by Defendants.

M. Award an amount to be proven at trial that will compensate Plaintiff for the severe and serious emotional distress that was caused by Defendants' failure to provide benefits according to Plaintiff's health insurance policy.

N. Award exemplary damages against FirstNation in an appropriate amount so as to punish and deter the wrongful and fraudulent behavior demonstrated herein.

O. Award such other and further relief as the Court deems equitable and just under the circumstances of this case.

DATED this 16th day of December, 2020.

Respectfully submitted

CARLEY CLAUSEN
Plaintiff

By: AARON J. VINCENT
Wyoming Attorney No. 6-4110
JOHN R. VINCENT
Wyoming Attorney No. 5-1350
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(307) 857-6005
(307) 857-6192 (Telefax)

AARON J. VINCENT

EXHIBIT 1

Billing codes
ID #

4.14.14 out of pocket estimate for insulin pump + supplies

7739.29
6421.69
SENSORS (CGM)

Medtronic
800.933.3322
Care Centric
Pump supplies

EASTERN SHOSHONE TRIBE

PLAN DOCUMENT

EASTERN SHOSHONE TRIBE

HEALTH CARE PLAN

Plan: 501

Sisco Customer Service
800-457-4726 x7112

also will get list of providers

EXHIBIT
tabbies
1

2112

DISCLAIMER OF CLAIMS ADMINISTRATOR

We have prepared these documents for your review and consideration, but we are not legal counsel, nor are we in the business of practicing law. As your plan's fiduciaries and/or trustees, you are fully responsible for all legal issues which concern the plan. If you are not an expert in this area, you may wish to consult an attorney to assist you in reviewing this plan.

TABLE OF CONTENTS

Eastern Shoshone Tribe hereby establishes a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA), as amended and as applies to government plans. By signing below, Eastern Shoshone Tribe agrees to be bound by the terms of the plan.

EASTERN SHOSHONE TRIBE

By: Karen Yaeger
Authorized Representative

Witnessed:

Date: 12 / 18 / 2012

By: Ramona Compton

307-851-6708

PLAN DESCRIPTION

Purpose

The Plan Document details the benefits, rights, and privileges of Covered Individuals (as later defined), in a fund established by Eastern Shoshone Tribe (the "Company") and referred to as the "Plan." The Plan Document explains the times when the Plan will pay or reimburse all or a portion of Eligible Expenses.

Effective Date of Plan	September 1, 2012
Name of Plan	Eastern Shoshone Tribe Health Care Plan
Name and Address of Plan Sponsor	Eastern Shoshone Tribe PO Box 538 Ft. Washakie, WY 82514
Name and Address of Claims Administrator	Self Insured Services Company (SISCO) P.O. Box 389 Dubuque, Iowa 52004-0389 (800) 457-4726
Name and Address of Review Organization	HealthCorp P.O. Box 1475 Dubuque, Iowa 52004-1475 (800) 457-4726
Employer I.D. Number	83-0261946
Plan Number	501
Type of Plan	A self-funded group health plan providing medical and prescription drug coverage and optional dental, vision and short term disability benefits
Agent For Legal Service	Eastern Shoshone Tribe
Funding of the Plan	Eastern Shoshone Tribe and Employee Contributions
Medium For Providing Benefits	The benefits are administered in accordance with the Plan Document by the Claims Administrator.
Fiscal Year of the Plan	Beginning January 1 and ends December 31

Health Services

In no event shall The Eastern Shoshone Tribe Employee Benefit Plan be liable for expenses or reimbursement for medical, surgical, hospital or related services to which the insured member is entitled to receive from or through the United States Public Health Service or any federally funded or sponsored Indian Health Service program. This applies if the patient will lose life, limb or vision within 72 hours.

Named Fiduciary and Plan Administrator

The Named Fiduciary and Plan Administrator is Eastern Shoshone Tribe, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator or its delegate has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, payment of benefits or claims under the Plan and any and all other matters arising under the Plan. The decision of the Plan Administrator will be final and binding on all interested parties.

Contributions to the Plan

The amount of contributions to the Plan are to be made on the following basis:

The Company will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Company and the amount to be contributed (if any) by each covered Employee. Notwithstanding any other provision of the Plan, the Company's obligation to pay claims otherwise allowable under the terms of the Plan will be limited to its obligation to make contributions to the Plan as set forth in the preceding sentence. Payment of said claims in accordance with these procedures will discharge completely the Company's obligation with respect to such payments. In the event that the Company terminates the Plan, then as of the effective date of termination, the Company and Covered Individuals will have no further obligation to make additional contributions to the Plan.

Plan Modification and Amendments

Subject to any negotiated agreements, the Company may modify, amend, or discontinue the Plan without the consent of or notice to Covered Individuals. Any changes made shall be binding on each Employee and on any other Covered Individuals. This right to make amendments shall extend to amending the coverage (if any) granted to retirees covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan

The Company reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the Company will continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Covered Individuals, until all contributions are exhausted.

Plan Is Not a Contract

The Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Employee of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Employee.

Claim Procedure

In accordance with Section 503 of ERISA, the Company will provide adequate notice in writing to any Covered Individuals whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Covered Individuals. Further, the Company will afford a reasonable opportunity to any Covered Individuals, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the Company for that purpose.

Protection against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Company finds that such an attempt has been made with respect to any payment due or to become due to any Covered Individual, the Company in its sole discretion may terminate the interest of such Covered Individual or former Covered Individual in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered Individual or former Covered Individual, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Covered Individual or former Covered Individual, as the Company may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment. This Provision does not prohibit a Covered Individual from assigning his benefits to an Eligible Provider.

Indemnification of Employees

Except as otherwise provided in ERISA, no director, officer, or Employee of the Company or of the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and will be indemnified and held harmless by the Company from and against any such personal liability, including all expenses reasonably incurred in his defense if the Company fails to provide such defense. The Company and the Plan may each purchase fiduciary liability insurance consistent with applicable law.

Grandfather Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the claims processor at 800-457-4726. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PLAN SUMMARY

FOR

EASTERN SHOSHONE TRIBE

Eligibility Provisions

Eligible Class

All Employees who work for the Company for at least 30 hours per week on a regular basis. Temporary, part-time, seasonal or contracted employees, consultants, and members of the board of directors are not eligible for coverage.

Required Period of Service

An Employee will be eligible for coverage on the first of the month coincident with or next following completion of 180 days of continuous Active Work.

Contribution

The Plan may be evaluated from time to time to determine the amount of Employee contribution (if any) required.

Changes in Eligibility

You should report any change in eligibility to your employer as soon as possible. Changes in eligibility include, but are not limited to:

- Marriage or divorce
- Death of a Dependent
- Birth or adoption of a child
- Dependent child reaching the limiting age

Managed Care

This Plan has a mandatory utilization review requirement called "pre-certification". Pre-certification is required prior to all scheduled Hospital admissions, Skilled Nursing/Extended Care admissions, and Outpatient services as outlined below. **Pre-certification does not guarantee that proposed admissions or Outpatient procedures are covered under the Plan as Eligible Expenses.**

Review Organization

The Review Organization for this Plan is:

HealthCorp
P.O. Box 1475
Dubuque, Iowa 52004-1475
1-800-457-4726

Hospital Pre-Admission Certification

The Plan requires that all non-emergency inpatient hospitalizations and Skilled Nursing/Extended Care Facility admissions be pre-certified by the Review Organization prior to the admission; all emergency inpatient hospitalizations must be reported within two (2) business days of admission. If an individual fails to pre-certify an inpatient stay with the Review Organization, Eligible Expenses related to the admission will be subject to a penalty as listed in the Plan.

The Covered Individual must inform the provider that he participates in a program, which has pre-certification requirements. In order to obtain pre-certification:

1. Notify the appropriate Review Organization of the upcoming Hospital or Skilled Nursing/Extended Care Facility stay no later than 24 hours prior to the admission. Emergency admissions to the hospital must be reported to the Review Organization within two (2) business days of the admission.
2. Notice can be given by: (a) the Hospital/Skilled Nursing/Extended Care Facility; (b) admitting Physician; (c) Covered Individual; or (d) a Family member of the Covered Individual, but **it is ultimately the responsibility of the Covered Individual to make sure a Hospital admission or Skilled Nursing/Extended Care Facility admission has been pre-certified.**
3. The Review Organization must be provided with information necessary to make a decision as to the Medical Necessity of the admission.

In regard to maternity or Newborn infant admissions, the health Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable).

A maternity or Newborn admission in excess of the 48/96 hour time frame requires calling the Review Organization for pre-certification of the additional stay.

Continued Stay Review

When the Review Organization provides pre-certification to the Covered Individual, the Review Organization will assign a certain number of inpatient Hospital days or inpatient Skilled Nursing/Extended Care Facility days for the stay. If any days are not Medically Necessary, and the Covered Individual remains beyond the Medically Necessary length of stay, the Covered Individual shall be liable for all Hospital/Skilled Nursing/Extended Care Facility charges beyond the Medically Necessary length of stay

Outpatient Management Pre-Certification

The Plan requires that the following scheduled procedures/services be pre-certified by the Review Organization, subject to its' guidelines, prior to receiving treatment/service. Emergency outpatient services do not require pre-certification. If the service is not pre-certified, Eligible Expenses related to the service will be subject to a penalty as listed in the Plan.

- Chemotherapy
- CT Scans
- Home Health Services
- Medical Equipment – purchase, if price is above $300 and all rentals
- MRA
- MRI
- PET Scan
- Radiation Therapy

Penalty for Non-Certification

If pre-certification is not obtained in connection with an Inpatient hospitalization, Inpatient Skilled Nursing/Extended Care Facility admission, or listed outpatient procedure/service, the Eligible Expenses will be reduced by 25% to a maximum penalty of $500. The additional penalty will be figured before the Deductible and coinsurance are applied. The penalty is not considered an Eligible Expense.

Case Management

When a catastrophic condition, such as a spinal cord Injury, cancer or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he might need extensive services or might be able to be moved into another type of care setting – even to his home.

Case management is a program whereby a case manager monitors a patient and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary Care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

Case management is a voluntary service. There are no reductions of benefits or penalties if a Covered Individual chooses not to participate.

Comprehensive Medical Expense Benefits

Your Plan utilizes a Preferred Provider Organization (PPO) which, through negotiation, offers discounts for using the preferred providers for your medical care. If you utilize the PPO providers for eligible services, you will receive the In-Network benefit listed below. To obtain a list of the preferred providers, contact your human resources department.

All services under the PPO Plan must be provided by participating providers to be covered at the In-Network benefit level. Services received elsewhere will be paid at the Out-of-Network level of benefits. However, if any of the following circumstances apply, benefits will be payable at the In-Network level of benefits:

- *The service is not available through the PPO.*
- *Emergency care.*
- *Ancillary services when the primary service is rendered by a PPO provider.*

Contract Health Services eligible Employees are eligible to have the following services paid at the Tribal fee schedule rate at Medicare participating inpatient hospitals with no deductible or coinsurance applied. These services will be paid as part of the Tribal fee schedule: Dental care services performed in a Hospital setting; Home IV therapy from inpatient hospital facility; inpatient hospital; outpatient hospital if attached to an inpatient hospital; hospital based clinic (Urgent Care); maternity inpatient facility charges; PT/OT/ST if billed by a hospital; Well Care services: facility charges when billed by a hospital; reconstructive surgery facility charges when bill by a hospital; skilled nursing facility; transplant facility claim only; emergency room services; and bariatric surgery. The following services are not eligible for the Tribal fee schedule: mental health and substance abuse services; home health care; hospice care; all professional services; pharmacy claims; and ancillary charges.

Maximum Annual Benefit for All Medical and Prescription Drug Expenses	Unlimited
Annual Individual Deductible	$1,000
Annual Family Deductible (All Family members combined)	$2,000
Annual Out-of-Pocket Maximum (Does not include the Annual Deductible, the benefit reduction for failure to comply with the Managed Care measures of the Plan, ineligible charges, service co-pays, or any amount over the Usual, Customary and Reasonable procedure rate.)	Individual: $1,000 Family: $2,000 (All Family members combined)

Benefit	In-Network	Out-of-Network
Alternative Care (includes Chiropractic care, Acupuncture, Biofeedback, Hypnosis or hypnotherapy, Holistic and Naturopathic medicines and /or treatments and massage therapy)	80% after Deductible	70% after Deductible
	Alternative Care is limited to $500 per Covered Individual per Calendar Year	

Benefit	In-Network	Out-of-Network
Ambulance	80% after Deductible	70% after Deductible
Durable Medical Equipment	80% after Deductible	70% after Deductible
Emergency Room Services	$50 co-pay, 80% after Deductible	$50 co-pay, 70% after Deductible
Co-pay is waived if admitted to the Hospital as a result of the emergency room visit. Non-emergency use of the emergency room is not an Eligible Expense. Determination of "non-emergency" is based on the Plan's definition of "Emergency".		
Extended Care/Skilled Nursing Facility	80% after Deductible	70% after Deductible
	Limited to 30 days per Calendar Year	
Home Health Care	80% after Deductible	70% after Deductible
	Limited to 100 visits per Calendar Year	
Hospice Care	80% after Deductible	70% after Deductible
Hospital Services (includes Inpatient and Outpatient services, except emergency room services)	80% after Deductible	70% after Deductible
	Pre-certification is required for Inpatient admissions. Failure to comply will result in reduction of benefits by 25% to a maximum penalty of $500.	
Mental Health and Substance Abuse Services	80% after Deductible	70% after Deductible
	Pre-certification is required for Inpatient admissions. Failure to comply will result in reduction of benefits by 25% to a maximum penalty of $500.	
Office Visits	80% after Deductible	70% after Deductible
Second and Third Surgical Opinions	100%, Deductible waived	100%, Deductible waived
	The Physician rendering the second opinion must be a specialist qualified to render such a service either through experience, specialist training or education, and must not be financially affiliated in any way with the Physician who initially recommended the surgery. If the second opinion and the initial recommendation for surgery do not agree, the Plan will pay for a third opinion.	
Surgery	80% after Deductible	70% after Deductible
	Pre-certification is required for Inpatient admissions. Failure to comply will result in reduction of benefits by 25% to a maximum penalty of $500.	
Therapy- Physical, Occupational, and Speech Therapy	80% after Deductible	70% after Deductible

Benefit	In-Network	Out-of-Network
Transplants	80% after Deductible	70% after Deductible
	Pre-certification is required for Inpatient admissions. Failure to comply will result in reduction of benefits by 25% to a maximum penalty of $500.	
Well Care	80% Deductible waived	70% Deductible waived
All Other Eligible Expenses	80% after Deductible	70% after Deductible

Prescription Drug Expense Benefit

Benefit Percentage	100% after the Prescription Co-Pay
Prescription Co-Pay (Per prescription and each refill of a prescription. Limited to a 30-day supply for one (1) co-pay at a retail pharmacy. A 31-60 day supply may be purchased for two (2) co-pays and a 61-91 day supply may be purchased for three (3) co-pays at a retail pharmacy. Up to a 91-day supply may be purchased through the mail order option for the listed co-pay.)	Retail: Generic: $10 Formulary Name Brand: $25 Non-Formulary Name Brand: $50 Mail Order: Generic: $20 Formulary Name Brand: $50 Non-Formulary Name Brand: $100 (If a name brand drug is purchased when a generic is available, the participant will be responsible for the difference in cost between the name brand and generic drug in addition to the name brand co-pay. This limitation will not apply if your Physician indicates that only the name brand drug may be taken.)

The Prescription drug coverage provided by this Plan is "creditable" to Medicare D. If you or one of your covered family members is eligible for Medicare, you may obtain a "creditable coverage" letter by contacting SISCO –800-457-4726.

Dental Expense Benefits

Optional Benefit

Annual Deductible	None
Benefit Percentage for Dental Expenses	
Class I (Diagnostic and Preventive Services)	100%
Class II (Basic Restorative Services)	80%
Class III (Major Restorative Services)	60%
Class IV (Orthodontia; limited to Dependent children up to age 20)	50%
Maximum Annual Benefit per Individual Classes I, II & III Combined	$1,250 per Covered Individual per Calendar Year
Maximum Lifetime Benefit per Individual Class IV	$1,500 per Covered Individual; limited to unmarried Dependent children up to age 20

Vision Care Expense Benefits

Optional Benefit

Deductible	None
Maximum Annual Benefit	$300 per Covered Individual per Calendar Year
Maximum Lifetime Benefit for Lasik Surgery	$500 per Covered Individual per Lifetime

Covered Services

- One eye examination per Covered Individual per Calendar Year
- One set of lenses or contact lenses per Covered Individual per Calendar Year
- One frame per Covered Individual per 24 months
- Lasik surgery subject to the limit listed above

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

Upon receipt of proof of loss, the Plan will pay the Benefit Percentage listed in the Plan Summary for Medically Necessary Eligible Expenses incurred in each Benefit Period. The amount payable in no event shall exceed any Maximum Benefit stated in the Plan Summary.

The Deductible

The Deductible is the amount of Eligible Expenses which must be paid each Calendar Year before Comprehensive Medical Expense Benefits are payable. The amount of the Deductible is shown in the Plan Summary. Each Family member is subject to the Deductible up to the Family maximum as shown in the Plan Summary.

Family Deductible Feature

If the Family Deductible limit, as shown in the Plan Summary, is incurred by covered Family members during the Calendar Year, no further Deductibles will be required on any Family members for the rest of the Calendar Year; each Family member's responsibility will be limited to the individual deductible as specified in the Summary of Benefits.

Deductible Carry-over Provision

The medical Deductible applies only once in any Calendar Year even though there may be several different Injuries or Illnesses. So that Comprehensive Medical Expense Benefits payments will not be subject to a medical Deductible late in one Calendar Year and soon again in the next following Calendar Year, any Eligible Expenses incurred in the last three (3) months of a Calendar Year and applied against the medical Deductible will reduce the medical Deductible for the next Calendar Year.

Out-of-Pocket Maximum

After the Annual Deductible is met, the Plan will pay the applicable percentages of Eligible Expenses as shown in the Schedule of Benefits. When a Covered Individual meets the Annual Out-of-Pocket Maximum as stated in the Schedule of Benefits, the Plan will pay 100% of additional Eligible Expenses for the remainder of that Calendar Year. Co-payments do not accumulate to the Annual Out-of-Pocket Maximum and continue when the Out-of-Pocket Maximum is met.

Co-payment

Co-payment is the fixed dollar amount you pay each time you receive certain covered services. The co-payment does not apply toward the Annual Deductible or out-of-pocket maximum and continues to be taken after the out-of-pocket maximum is met.

Allocation and Apportionment of Benefits

The Company reserves the right to allocate the Deductible amount to any Eligible Expenses and to apportion the benefits to the Covered Individual and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Individual and all assignees.

Temporary Disability Income Benefits

Optional Benefit

Available to Employees only. Dependents are not eligible for this coverage.

Waiting Period*	First seven (7) days of any disability period due to illness. There is no waiting period for disability due to injury.
Maximum Period of Payments	26 weeks per period of Disability
Weekly Payment	60% of salary up to a maximum of $400 per week

*Prior to the beginning of the waiting period, any available sick leave hours must be exhausted. Once all available sick leave hours are used, the waiting period/benefit will begin.

Medical Eligible Expenses

Medical Eligible Expenses are the following Medically Necessary expenses that are incurred while Plan coverage is in force for the Covered Individual. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Individual's condition, or that a plateau has been reached in terms of improvement from such services. If any of the listed expenses are excluded from coverage because of a reason described in the General Limitations section or any other Plan section, those expenses will not be considered medical Eligible Expenses.

The Plan will make payment for medical Eligible Expenses subject to the Benefit Percentage and maximum amounts shown in the Plan Summary. All services are subject to the Usual, Customary, and Reasonable allowance as defined in the Plan.

Hospital Expenses

Hospital expenses are the charges made by a Hospital on its own behalf. Such charges include:

1. Semi-Private Room and Board. If a facility has only private rooms, or if a private room is Medically Necessary due to the diagnosed condition, the private-room rate will be allowable.
2. Necessary Hospital services other than Room and Board as furnished by the Hospital.
3. Special care units, including burn care units, cardiac care units, delivery rooms, Intensive Care Units, isolation rooms, operating rooms and recovery rooms.
4. Outpatient charges to include observation up to 23 hours. Observation in excess of 23 hours will be allowed based on the inpatient benefit of the Plan.

If an Inpatient hospital confinement begins in one calendar year and ends in another calendar year, all services are to be interpreted as incurred in the calendar year in which the hospitalization began.

Skilled Nursing Facility/Extended Care Facility Expenses

Eligible Skilled Nursing Facility/Extended Care Facility expenses under this benefit include:

1. Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis, such as general nursing services. The daily Room and Board charges allowed will not exceed the average semi-private rate.
2. Medical services customarily provided by the Skilled Nursing Facility or Extended Care Facility, with the exception of private-duty or special nursing services and Physician fees.
3. Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

Hospice Expenses

A Hospice program provides care for patients who are terminally ill. The following services and supplies provided by a Hospice are covered:

1. Nursing care by a Registered Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse.

2. Physical therapy, occupational therapy and speech therapy, when rendered by a licensed therapist.
3. Medical supplies, including drugs and biologicals, and the use of medical appliances.
4. Physicians' services.
5. Services, supplies, and treatments (including Inpatient Hospice care) deemed Medically Necessary and ordered by a licensed Physician.
6. Respite Care offers rest and relief help for the Family caring for a terminally ill patient. Eligible inpatient respite care can take place in a Hospital, Skilled Nursing Facility/Extended Care Facility or nursing home. Respite care must be used in increments of not more than five (5) days at a time.

Home Health Care Expenses

Home health care expenses are the charges made by a Home Health Care Agency for the following services and supplies which are ordered by a Physician and furnished to a Covered Individual in his home in accordance with a Home Health Care Plan.

1. Part-time or intermittent nursing care provided by a Registered Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse.
2. Part-time or intermittent home health aide services which consist primarily of caring for the patient, and are under the supervision of an R.N. or L.P.N.
3. Medical supplies, drugs, and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a licensed medical provider, but only to the extent that such charges would have been covered if the Covered Individual had remained in the Hospital or a Skilled Nursing Facility/Extended Care Facility.
4. Charges for physical, respiratory, speech or occupational therapy.
5. Charges for parenteral or enteral nutrition.
6. Charges for inhalation therapy
7. Medical social services.

Home health care expenses will not be covered if they are:

1. For services or supplies not specified in the Home Health Care Plan.
2. For services by a Close Relative or member of the household.
3. For services for a period during which an Employee or Dependent is not under the continuing care of a Physician.
4. For transportation services.

Each visit, up to two (2) hours, by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) to provide nursing care, by a therapist to provide physical, occupational or speech therapy, and each visit of up to four (4) hours by a home health aide shall be considered as one home health care visit.

Organ/Tissue Transplant Expenses

Benefits are available to a Covered Individual who is a recipient or donor for Medically Necessary covered services relating to bone marrow, liver, heart, lung (single and double), combination heart/lung,

pancreas, pancreas/kidney, kidney, cornea and any other non-Experimental transplant. Eligible Expenses include, but are not limited to: testing to determine transplant feasibility and donor compatibility; charges related to the transplant itself, as well as follow-up care to include: diagnostic x-ray and lab; procedures to determine rejection or success of transplant, to include: Physician, lab, x-ray or Hospital charges, and anti-rejection drugs.

Organ transplant expenses are those charges for services and supplies in connection with non-Experimental, human to human, transplant procedures, subject to the following criteria:

1. Except for transplant of a cornea, the recipient must be in danger of death in the event the organ transplant is not performed.
2. There must be a reasonable expectation of survival if the Covered Individual were to receive the transplant.
3. Charges incurred by the donor are only payable if the donor is covered by this Plan. If only the donor is covered by this Plan, payment by this Plan will be secondary to any other coverage available to the donor.
4. Pre-approval is required.

The following will not be eligible for coverage under this benefit:

1. Expenses associated with the purchase of any organ.
2. Charges in connection with mechanical or non-human organs or a transplant involving a mechanical organ.
3. Services or supplies furnished in connection with the transportation of a living donor.

Physician Services

The Plan will allow Physician charges according to Usual, Customary, and Reasonable (UCR) guidelines for medical care and/or surgical treatments, including office or home visits, Hospital Inpatient care or Outpatient care, clinic care, ambulatory surgery care, and Medically Necessary care provided at a licensed outpatient facility. Payment for multiple Surgical Procedures (not including the primary Surgical Procedure) performed at the same time may be reduced to 50% of the UCR amount. If the multiple Surgical Procedure is determined incidental, benefits will be denied. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual, Customary and Reasonable allowance.

Eligible Expenses In or Out of the Hospital

1. Allergies: Charges for testing treatment for allergies, including percutaneous, intracutaneous, and patch testing and allergy extract/injections.
2. Alternative Care: Charges incurred for all treatment of a covered person involving manual manipulation, including treatment modalities (including, but not limited to chiropractic care, spinal adjustments, diathermy, heat or cold therapy, massage, acupuncture, electrical stimulation and/or biofeedback for spinal skeletal system and/or surrounding tissue), hypnosis or hypnotherapy, holistic and naturopathic medicines and/or treatments will be considered and processed subject to the Alternative Care limited benefit shown in the Schedule of Medical Benefits of this Plan. Charges for such services in excess of the stated benefit maximum will not be considered eligible for processing or payment under any other provision of this Plan.

3. Ambulance: Charges for professional land, air or sea ambulance service to the nearest medical facility qualified to treat the emergency Illness or Injury or when Medically Necessary, from one facility to another for care. Sea or air ambulance is covered only due to inaccessibility by ground transport, and/or if the use of ground transport would be detrimental to the health status of the patient. Ambulance charges for the convenience are not covered.

4. Ambulatory Surgical Center: Charges made by an ambulatory surgical center or minor emergency medical clinic.

5. Amniocentesis Testing: Charges for amniocentesis testing, genetic testing, counseling and treatment when recommended by a physician for a covered person who is 35 years of age or older at the time of delivery, or for a physician documented high-risk pregnancy or physician documented family history of genetic disorder. Any procedure intended solely for sex determination is not covered.

6. Anesthetics: Charges for anesthetics and their administration, including epidurals, by a physician or by a nurse anesthetist (CRNA).

7. Artificial Limbs: Charges for external prosthetic and orthopedic appliances such as artificial legs, arms, eyes or larynx or accessories, braces, splints, cervical collars or other orthopedic appliances, required to replace a lost natural body part, or are required for support for an injured or deformed part of the body as a result of disabling congenital condition or illness or injury. Benefits include charges for the fitting, adjusting, repair or maintenance of such prosthetic and orthopedic appliance. Charges for replacement of the prosthetic appliance will be covered only if the Plan is shown that it is needed due to a change in the person's physical condition. Replacement due to technological advancement only is not covered. Only conventional, body powered, cable-operated prosthetics will be eligible for loss of a limb or disarticulation when a cable-operated prosthetic is totally non-functional.

8. Assistant Surgeon: Charges for an assistant surgeon when the procedure requires an assistant due to medical necessity. Charges are calculated at 20% of the reasonable and customary covered surgeon's fees.

9. Attention Deficit Disorder: Charges for eligible initial diagnostic testing to determine the diagnosis, medication, and medical management of medication for attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD).

10. Behavioral Problems: Charges consisting mainly of behavioral problems, communication delays, conduct problems, learning disabilities, developmental delays, autism, or for scholastic improvement.

11. Birthing Center: Charges made by a licensed birthing center for services or supplies that would have been payable if performed in a Hospital.

12. Birth Control: Charges for birth control injections, diaphragm, Norplant implant and removal, insertion and removal of an IUD, elective sterilization for employee or covered spouse. Prescription birth control pills/patches are covered under the "Prescription Drug Program".

13. Blood: Charges for processing, administration, and/or storage of pre-surgical antilogous blood and cost of blood, blood components, or other fluids, unless it is donated or replaced.

14. Breast Surgery: Charges for breast reconstruction in connection with covered mastectomy will include (a) reconstruction of the breast on which the covered mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complication of all stages of covered mastectomy, including lymphedemas.

    Breast reduction when prescribed by a physician and, in the sole discretion of the Plan Administrator, such procedure is deemed to be medically necessary in order to prevent or correct deformities or to improve bodily function. Failure to submit all requested medical records and any supporting documentation requested by the Plan will result in denial of benefits for all charges associated with such procedure, including complications.

15. Chemotherapy and Radiation Therapy.

16. Cardiac Rehabilitation: Charges for cardiac rehabilitation programs to provide supervised monitored exercise sessions following heart surgery, a heart attack, or when medically necessary for a heart condition as prescribed by the physician.

17. Chiropractic Services: See "Alternative Care" provision.

18. Circumcision: Charges for or in connection with a routine or medically necessary circumcision.

19. Dental Prostheses: Charges for dental prostheses used to treat birth defects, trauma, or accidental injury; or as used with respect to radiation, chemotherapy or surgery for cancer. Implants are not a covered benefit.

20. Diabetes Training and Equipment: Charges for diabetes self-management training including: (a) training provided after initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and diabetes supplies; (b) additional training authorized on the diagnosis of a health care practitioner of a significant change in the covered person's symptoms or condition of diabetes that requires changes in the covered person's self-management regime; or (c) periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatment for diabetes.

    Diabetic equipment including but not limited to, blood glucose monitors (including monitors designed to be used by blind individuals), and podiatric appliances for the prevention of complications associated with diabetes. Diabetes supplies, including but not limited to, needles, syringes, lancets, dextrostix, and insulin are covered under the "Prescription Drug Program".

21. Dialysis: Charges for outpatient and/or inpatient dialysis.

22. Drugs: Charges for drugs requiring the written prescription of a licensed physician and dispensed in a physician's office, or by a hospital, ambulatory, emergency, or urgent care facility and self-administered injectable drugs are covered under the Medical portion of the Plan, and not under the Plan's "Prescription Drug Program". Refer to "Prescription Drug Program" section for a further description of drug coverage.

23. Durable Medical Equipment: Charges for rental of durable medical equipment required for temporary therapeutic use, or the purchase of this equipment if, in the opinion of the Plan Administrator, purchase is economically justified. The Plan reserves the right to pay monthly rental not to exceed the purchase price. Repair, maintenance, or replacement of durable medical equipment and accessories will not be covered unless such services are determined to be medically necessary as defined in this Plan. Replacement will be covered only if the Plan is shown that: (a) it is needed due to change in the person's physical condition; or (b) it is likely to cost less to buy a replacement than to reqair the existing equipment or to rent like equipment.

    Covered expenses will be limited to the price of one standard model of equipment. Deluxe equipment such as motor driven wheelchairs and beds are not covered except when such features are Medically Necessary for the effective treatment of a patient's condition and the patient cannot otherwise operate the equipment himself.

24. Education Programs: Charges for medically necessary patient education programs, at the onset of a medical condition that is necessary to the proper care of that condition, or to further training caused by a change in the medical condition or development of new treatment methods, including but not limited to cardiac education and ostomy care.

25. Enteral or Parenteral Nutrition: Charges for medically necessary to sustain life.

26. Foot care: Charges for medically necessary treatment of the feet including but not limited to, weak, unstable feet, bunions, and flat feet.. The purchase of orthopedic appliances or other custom molded devices to be attached to or placed in shoes designed to relieve stresses of the foot. Orthopedic shoes are not covered unless part of a brace. Charges for trimming, removal of corns, calluses, or trimming of toenails, are only covered when medically necessary for the treatment of a metabolic or peripheral vascular disease. Covered foot surgery is limited to open cutting procedures of the foot and removal of the nail or nail root.

27. Impotency: Charges for testing to establish a diagnosis of impotency, erectile dysfunction, sexual dysfunction or inadequacy, or frigidity are covered up to the time treatment begins; once treatment begins, diagnostic and evaluation services are not covered.

28. Lab and X-ray Services: Charges for technical and professional fees associated with diagnostic laboratory services, pathology tests, x-ray services, or for radiation therapy, chemotherapy, radium and radioactive isotope therapy treatment.

29. Maternity: Charges for maternity expenses will be payable on the same basis as any other illness. Total obstetrical care includes but is not limited to, prenatal office visits, delivery, epidurals, postnatal office visits, midwife, and childbirth center charges. Fetal surgery will be considered as part of the mother's care.

30. Newborn Baby Care: A newborn child must be properly enrolled in order for any benefits to be payable. Charges for well-baby care from birth until the infant is discharged from the hospital, subject to the newborn's own deductible and out-of-pocket maximum.

    Charges for an ill newborn child are subject to the baby's own deductible and out-of-pocket maximum and payable as any other illness; a separate hospital admission notification must be made to the pre-certification service for a newborn that must remain in hospital due to necessity. This notice must be made within 2 working days of the newborn becoming ill.

31. Outside the USA: Charges incurred for a covered illness or injury while traveling outside the United States of America (USA) on a business or pleasure. Medical expenses for care, supplies, or services that are rendered by a provider whose principal place of business or address for payment is located outside the United States (a non-U.S. provider) are payable under the Plan subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions: (a) Charges incurred outside the USA, when the primary purpose is to obtain medical care, services, drugs, or supplies, are not covered; (b) Benefits may not be assigned to a non-U.S. providers, and submitting itemized receipts to the Plan for reimbursement; (d) Claims for benefits must be submitted to the Plan in English; and (e) Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date.

32. Oxygen: Charges for oxygen and rental of equipment for its administration, and other inhalation therapy.

33. Physician Services: Charges for the services of a legally qualified for medical care and surgical treatments including office, home visits, hospital inpatient care, hospital outpatient visits, exams, and clinic care, subject to provisions, limitations and exclusions shown elsewhere in this Plan.

34. Pre-admission Testing: Charges for pre-admission testing for covered lab, x-ray, and other medically necessary tests performed on an outpatient basis prior to a scheduled hospitalization. The charges must be related to the illness or injury that ultimately causes confinement. Pre-admission testing that is repeated in the hospital will not be paid unless medically necessary.

35. Private Duty Nursing: Charges for private duty nursing only when approved as medically necessary and covered under this Plan by the Plan Administrator.

36. Psychiatric Care: Charges for psychiatric care for mental health disorders, including eating disorders, substance abuse (chemical dependency, alcoholism and/or drug addiction), furnished on an inpatient or outpatient basis by a Hospital, or residential treatment facility, physician, or licensed therapist/counselor. Eligible Expenses include Inpatient, Outpatient and partial confinement.

37. Rehabilitation Services: Charges for rehabilitation services incurred for an Illness or Injury that results in the need for rehabilitation provided or offered in a rehabilitation hospital or center. The patient must be under the care of a physician for any benefits to be payable.

"Rehabilitation services" means a formal program of treatment that"

a. Is provided to those individuals who have severe disabiling impairments of recent onset or recent progression or persons who require an identifiable intensity of services; and
b. Is performed in a rehabilitation hospital or center either an Inpatient or an outpatient; and
c. Is prescribed by a physician as medically necessary and is periodically reviewed; and
d. Is prescribed in place of a stay in the acute setting of a Hospital or is an extension of a hospital stay; and
e. Is provided in a Hospital or facility that is licensed and qualified to render rehabilitation services.

The primary emphasis of the program is providing, in a coordinated manner, those comprehensive services deemed appropriate to the eneds of a person with a disability, in a program designed to achieve objectives of improved health, welfare and the realization of

one's maximum physical, social, psychological and vocational potential for useful and productive activity.

Services must be of such level of complexity or the condition of the patient must be such that services can be safely performed only by the qualified therapist or physician.

Mental health disorders, chemical dependency (alcoholism and drug) rehabilitation expenses are not covered under this provision.

38. Restoration or Reconstructive Surgery: Charges for restoration or reconstructive surgery when such surgery is required and performed to correct damage caused by (a) injuries sustained in an accident, and the reconstructive surgery is performed within 12 months of the date of the accident, or (b) medically necessary surgery, and reconstructive surgery is performed within 12 months of the date of such surgery, or (c) a birth defect or abnormal congenital condition in a covered dependent child born while covered under this plan that results in the malformation or absence of a body part, or (d) reconstructive surgery following a covered mastectomy, symmetrical reconstruction of the other breast following a covered mastectomy, and prostheses and treatment of physical complications of all stages of covered mastectomy, including lymphedemas; or (e) breast reduction if Medically Necessary (as defined in this Plan)

39. Second Surgical Opinion: Charges for a second opinion, when a physician advises that surgery is required in a non-emergency situation. The physician rendering the second opinion must be a specialist qualified to render such a service either through experience, specialist training or education, and must not be financially affiliated in any way with the physician who initially recommended the surgery. If the physician who originally recommended the surgery and the second opinion physician disagree, the Plan will also pay for a third opinion.

40. Sterilization: Charges for elective sterilization surgical procedures (vasectomy and tubal ligation or occlusion) for employees and covered spouses (but not the reversal of such procedures).

41. Surgery: Charges for a surgical procedure performed by a physician, nurse practitioner, or licensed midwife. More than one surgery performed by one or more physicians during the course of only one operative period is called a "multiple surgery". Surgical benefits are payable whether the operation is performed in the hospital, surgery facility or in the doctor's office.

42. Teeth: Charges incurred for treatment on or to the teeth or the supporting tissues of the teeth or the supporting tissues of the teeth related to; (a) removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination or accidental bodily injury; (b) treatment required because of accidental injuries to sound natural teeth, (which are teeth that are whole or properly restored, are without impairment or periodontal disease, and are not in need of treatment for reasons other than for the dental injury), and to the jaws, cheeks, lips, tongue, roof and floor of the mouth, providing such treatment is received within 12 months from the date of the accident; (c) treatment of fracture of facial bones; (d) incision and drainage of cellulitis (inflammation of soft tissue); (e) incision of accessory sinuses, salivary glands or ducts; (f) frenectomy (the cutting of the tissue in the midline of the tongue; and (g) dental prostheses used to treat birth defects. Trauma, or accidental injury; or as used with respect to radiation, chemotherapy, or surgery for cancer.

For purposes of this coverage, an accident does not include any injury caused by biting or chewing.

If hospitalization is necessary to safeguard the health of the patient for performance of a dental procedure that is not eligible for coverage under the Medical Expense Benefits provision of this Plan, the Plan will pay covered hospital, pathology, radiology, and/or anesthesiologist charges associated with such procedure. The plan will not pay for the charges of the physician, dentist, and/or oral surgeon in relation to the non-covered dental procedure even if the hospital charges are paid.

43. Therapist Services: Subject to the pre-certification requirements of the Plan, charges for a licensed therapist and associated supplies when treatment is recommended by physician for the following:

    a. **Speech therapy and audio therapy** including audio diagnostic testing, to provide developmental and rehabilitative care where there is a reasonable expectation that the services will produce significant improvement in the covered person's condition in a reasonable period of time.
    b. **Physical or occupational therapy** and supplies to provide rehabilitative care for an illness or injury, where there is a reasonable expectation that the services will produce significant improvement in the covered person's condition in a reasonable period of time. Such therapy does not include the services of a chiropractor, masseur, or physical education instructor.
    c. Respiratory (inhalation) therapy.

44. Urgent Care Facility: Charges incurred for treatment at an urgent care or walk-in facility.

45. Well Care Services: Charges for Well Care services (routine and preventive) are payable as shown in the Schedule of Medical Benefits for: (a) routine mammogram screening; (b) routine prostate screening; (c) colo-rectal cancer screenings; (d) routine physical exams; (e) routine diagnostic tests including, but not limited to, pap smears, EKGs, blood tests; (f) routine well-child examinations and checkup charges; (g) immunizations, vaccinations, and inoculations; (g) and any charge for check-up purposes not incident to or necessary to treat an illness or injury. Doctor visits for treatment of sickness or injury shall be processed under this Plan as any other illness. Sports, employment, licensing, and camp physicals are not covered.

PRESCRIPTION DRUG EXPENSE BENEFIT

The Plan will pay the Usual, Customary and Reasonable charge of Prescription drugs, less the co-payment listed in the Plan Summary which is payable by the Covered Individual for each Prescription and each refill of a Prescription. The Prescription co-payment is not an Eligible Expense under the medical benefits portion of this Plan.

The Prescription Drug Program will not cover the cost of administration of any drug.

Any prescription totaling $1,000 or more will be reviewed for medical necessity and therapeutic interchange. Any compound prescription over $200 will also be reviewed at the pharmacy level.

The Plan has a Preferred Brand list of prescription drugs for which discounts are received. This list may change from time to time. When using these Preferred Brand drugs, you will be responsible for the co-pay as listed in the Plan Summary. If you purchase a brand name drug that is not on the Preferred list, you will be responsible for a greater co-pay as stated in the Plan Summary.

If an individual is unable to use a particular drug on the company's preferred list, he may be able to purchase a non-preferred drug and only pay the preferred brand co-pay. Pre-authorization is required to obtain the drugs at the lesser co-pay. To obtain pre-authorization, have your physician send a letter to SISCO documenting the reason you are taking a non-preferred drug. The letter will be reviewed based on the guidelines listed below and you will be notified as to whether or not the substitution is allowed. Pre-authorizations are only issued to a member in cases of:

a) Documented prior failures on Formulary or Preferred Agents.

b) Medical necessity - i.e. current Preferred or Formulary alternatives are not acceptable according to current peer-reviewed medical literature.

c) Off-label use of medication

d) Over-ride an existing quantity limitation provided a specific dosing and tapering schedule is presented.

Pre-authorization requests will not be approved for members requesting an exemption from the highest co-payment to the middle co-payment unless the above stated criteria are appropriately documented by your physician. You and your healthcare provider may decide that a medication in the Non-preferred brand name category (3rd tier) is best for you. In this case, your prescription drug card benefit program does provide coverage for you, but you will share in the cost of the drug through the highest co-pay amount.

Your healthcare provider should prescribe medications which he feels best treats your disease state or medical condition. Pre-authorization forms may be obtained from your benefits coordinator or the claims processor. Pre-authorization request forms must be completed in full prior to evaluation of your request.

Covered Medications

1. All drugs, prescribed by a Physician that require a prescription either by federal or state law, except drugs excluded by the Plan.
2. All compound prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. Insulin, the syringes necessary for its' administration, and diabetic supplies when prescribed by a Physician.
4. Legend Drugs.

5. Contraceptives.
6. Specialty oral medications.
7. Growth hormones (with prior approval).
8. Prescription vitamins.

Excluded

Under this program, the following drugs are never covered, regardless of use or diagnosis:

1. Any drug for which reimbursement is available under any other group program or government program.
2. Drugs dispensed from or by any Hospital, Skilled Nursing Facility/ Extended Care Facility, clinic, or other institution to a Covered Individual as an Inpatient or Outpatient; such drugs are covered by the medical portion of the Plan.
3. Drugs dispensed by other than a retail or mail order pharmacy.
4. Drugs that do not require a written Prescription of a licensed Physician (with the exception of insulin, the syringes or needles for its administration, and diabetic supplies).
5. Injectables with the exception of injectable drugs for the treatment of migraine headaches, insulin, Glucagon and EpiPen.
6. Fertility drugs.
7. Devices or appliances (except for needles and syringes necessary for the administration of insulin and diabetic supplies).
8. Refills of a Prescription that is more than one (1) year old.
9. Nutritional supplements;
10. Cosmetic treatments.
11. Drugs or supplies associated with weight reduction.
12. Over the counter medications, except as specifically listed.
13. Smoking cessation drugs.
14. Drugs for sexual dysfunction and/or impotency.
15. Drugs dispensed outside the United States, except as required for emergency treatment.
16. Anabolic steroids.
17. Fluoride products.
18. Immunization agents.
19. Mouthwashes.
20. RU486 – abortion pill.
21. Amphetamines – central nervous system stimulant, Ritalin

Some Prescription items are limited based on FDA approved dosing schedules, current medical practices, evidence based clinical guidelines, and peer-reviewed medical literature related to that particular drug.

COMPREHENSIVE DENTAL EXPENSE BENEFITS

Subject to the General Limitations section of this Plan and the limitations of this section, Usual, Customary and Reasonable charges incurred for the following Covered Dental Expenses will be covered in accordance with the percentage of coverage, Deductible amounts and maximums in the Plan Summary.

A pre-treatment review is recommended on all charges that will result in a payment of $200 or more unless it can be shown that treatment was made on an emergency basis.

Dental Eligible Expenses

The term "Dental Eligible Expenses" means the expenses incurred by or on behalf of a Covered Individual for charges made by a Dentist for the performance of dental service provided for in the Plan Summary when the dental service is performed by or under the direction of a Dentist, is essential for the necessary care of the teeth, and begins while the Covered Individual is covered for Dental Benefits. If the actual performance of a dental service begins on a date other than the date the service was recommended or determined to be necessary, the dental service will be considered to begin on the date the actual performance of the service begins. For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened. All other expenses are considered incurred at the time a service is rendered or a supply furnished. Covered Dental Expenses do not include any expenses that are in excess of the Usual, Customary and Reasonable amount.

If a condition is being treated for which different treatments are suitable, the benefits under this Plan will be based on the service that, according to a determination made by the Plan Administrator, would produce a professionally satisfactory result.

Class I - Diagnostic & Preventive Services

1. Oral examinations and routine cleaning (prophylaxis) of teeth, but not more than twice per Calendar Year.
2. Fluoride applied to the teeth, but not more than twice per Calendar Year; limited to Dependent children up to age 16.
3. Emergency oral exam and palliative treatment.
4. Consultation or other office visits if no other dental service is performed on the same date.
5. Bacteriological studies and histopathological examinations.
6. Dental x-rays:
   a. Full mouth (single or multiple films), but not more than once every three (3) years;
   b. Bitewing x-rays, but not more than once every Calendar Year.
   c. Periapical, occlusal and extra oral x-rays when dentally necessary and appropriate.

Class II - Basic Restorative Services

1. Oral surgery, including pre- and post-operative care, general anesthesia, local anesthetic and injectable antibiotics.
2. Extraction of teeth.

3. Regular cavity fillings, including amalgam, synthetic porcelains, composite and plastic fillings and stainless steel restorations.
4. Local anesthesia or analgesia in connection with a covered procedure.
5. Cast restorations for advanced tooth decay or fracture are allowable once every five (5) consecutive years beginning from the date the cast restoration was cemented in place. Restorations include inlays, onlays, and crowns (including porcelain, porcelain fused, or precious metal crowns and related post and core). Crowns placed for the primary purpose of periodontal splinting, altering vertical dimension or restoring occlusion are not an Eligible Expense.
6. Charges for injections of antibiotic drugs by the attending dentist.
7. Space maintainers to replace prematurely lost primary teeth but only for Dependent children up to age 14.
8. Sealants, limited to Dependent children at least age six (6) but under age 16, and limited to permanent molars.
9. Relining or repair of crowns, inlays, onlays, dentures or fixed bridges.
10. Periodontics.
11. Endodontics.

Class III - Major Restorative Services

1. Initial placement of fixed bridgework including wing attachments, inlays, onlays and crowns used as abutments to the bridge.
2. Charges for the initial placement of partial or full dentures, including repairs and adjustments following the initial placement, provided:
   a) If a cast chrome or acrylic denture will restore the dental arch satisfactorily, payment will not be made toward a more elaborate or precision appliance. Any balance will be the responsibility of the Covered Individual.
   b) If a personalized restoration or specialized technique is chosen, payment will not be made for more than the cost of the standard service. Any balance will be the responsibility of the Covered Individual.
3. Charges for precision attachments, precision partials and treatment partials.
4. Replacement of an existing partial, full denture or fixed bridge, the addition of teeth to an existing partial or fixed denture, or bridgework to replace extracted teeth if satisfactory evidence is presented to the Plan that: 1) the replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed; 2) the existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to the replacement date; and/or 3) the existing denture is an immediate temporary denture replacing one or more extracted teeth, replacement by a permanent denture is required, and the replacement takes place within six (6) months from the placement of the temporary denture.
5. Charges for transplanting teeth or implanting fabricated teeth.
6. Charges for appliances or treatments for altering vertical dimension or to restore proper bite; for restoring occlusion, for replacing tooth structure lost from attrition, abrasion or erosion; for correcting congenital or developmental malformations; or for aesthetic purposes.

Class IV – Orthodontics (treatment must begin after your effective date under the Plan; services are available to dependent children up to age 20)

Services for the proper alignment of teeth.

Benefits under this Plan for orthodontia will be payable:

a. immediately upon receipt of proof that the initial treatment (including setting of the appliance or bands) has been completed; and

b. at the end of each following month/calendar quarter upon receipt of proof that the period of orthodontic treatment has continued.

The benefit amount payable for the initial treatment will be actual charges, but not more than 25% of the total estimated covered charges for the entire period of orthodontic treatment. Monthly/quarterly payments will be determined by averaging the remaining estimated covered charges over the estimated time required to complete the period of orthodontic treatment. Adjustments may be made when changes occur in the estimated covered charges or estimated period of treatment.

Alternate Benefit Provision

When more than one dental service could provide suitable treatment based on common dental standards, the Claims Payer will determine the dental services on which payment is based and the expenses that will be included as Eligible Expenses.

Limitations

1. Charges for services or supplies which have the primary purpose of improving the appearance of the teeth, rather than restoring or improving dental form or function. Some examples include: laminate and veneers.
2. Charges for infection control procedures (sepsis control - rubber gloves, gowns, etc.) when billed separately from actual dental treatment.
3. Charges for oral hygiene, dietary instruction or plaque control programs.
4. Charges for services or supplies you are not legally obligated to pay for and for which you would not be charged in the absence of this Plan.
5. Charges for the replacement of lost or stolen appliances.
6. Charges for services or supplies that you are entitled to claim from any governmental program even if you waived or failed to claim rights to such services, benefits, or damages.
7. Charges for athletic mouth guards, night guards, or occlusal guards, including replacement, repair, relines or adjustments.
8. Charges for Prescription drugs.
9. Charges for repair or replacement of any orthodontic appliance.
10. Charges for any service or supply that could have been compensated under workers' compensation laws, including any services or supplies applied toward the satisfaction of any Deductible under your employer's workers' compensation coverage.
11. Charges for services or supplies for any treatment plan when you receive the services or supplies after the date of termination of coverage under this Plan.

12. Charges for services or supplies related to a service that began prior to the effective date of coverage.
13. Charges related to TMJ (temporomandibular joint disorder).
14. Charges for services which are covered under a medical plan sponsored by the Company will not be coordinated with the Dental benefits provided by the Company.
15. Charges for periodontal splinting.

VISION CARE EXPENSE BENEFITS

Vision care benefits apply only when vision care charges are incurred by a Covered Individual and when the charges are for services that are recommended and approved by a Physician or Optometrist. Benefits will be payable as outlined in the Plan Summary for each vision care service or supply.

No benefits will be payable for:

1. Charges for orthoptics (eye muscle exercises).
2. Charges for vision training or subnormal vision aids.
3. Charges for lenses ordered without a prescription.
4. Charges for safety goggles, including prescription type.
5. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
6. Charges excluded or limited by the Plan design as stated in this Document.
7. Charges for sunglasses.
8. Charges for tints, over-sizing or any cost above the basic lens fee.

TEMPORARY DISABILITY BENEFIT

The Plan will pay a benefit for an absence caused by a non-occupational disability which prevents a participating Employee from working due to Illness or accidental Injury.

The maximum amount the Plan will pay is the amount shown in the Plan Summary. Participating Employees are subject to all other stipulations of the Plan, to include but not be limited to eligibility, maximums, waiting periods, benefits or special limitations, except the Pre-Existing Limitation will not apply to this benefit. The Plan will pay benefits to the maximum number of weeks for each separate disability as shown in the Plan Summary. Two or more periods of disability due to the same cause are considered one period of disability, unless they are separated by a return to full-time work for a continuous period of at least two (2) weeks. Two or more periods of disability due to unrelated injury or illness are considered one period of disability unless separated by return to regular full-time work of at least one full day. If the participating Employee returns to light-duty work and that work assignment subsequently ends, the Participating Employee will not be required to satisfy a new waiting period for disability benefits. This shall be considered one continuing period of disability; however, the maximum number of weeks of disability benefits for this continuous disability shall not exceed the maximum shown in the Plan Summary.

The waiting period before benefits commence is the time shown in the Plan Summary.

Should a participating Employee die during the time for which he is receiving disability benefits, such benefits shall be paid up to and including the date of death, or until the Maximum Benefit is reached, whichever is less.

In order to receive benefits, the participating Employee must be under a physician's care and cannot receive compensation or profit for doing any work anywhere and must have exhausted all available sick leave. Disability benefits are not payable for any period of time during which a participating Employee is compensated for work-related illness or injury. In the case of a non-occupational disability that commences while the participating Employee is on layoff, suspension, leave of absence, or vacation and a return to work date has been determined and the participating Employee has been notified, no benefits will be payable until the date the participating Employee would normally have returned to work had the injury or illness not occurred. To be eligible for benefits, the participating Employee must have worked on the last scheduled work day prior to the beginning of the layoff, suspension, leave of absence, or vacation. If a participating Employee is unable to work due to a work-related illness or injury and he is subsequently released from the doctor's care but is unable to return to work due to a non-occupational injury or illness which occurs or commences during the time off work, he shall be considered eligible for benefits under this Plan if he had worked on the last scheduled work day prior to the work-related disability.

In cases where the effective date of a participating Employee's discharge has been determined and the individual has been notified, or where a participating Employee has submitted his resignation, such individual who becomes eligible for benefits before such discharge or resignation becomes effective shall be paid benefits only until the effective date of the resignation or discharge.

A participating Employee must reimburse the Plan for any disability benefits received as the result of fraud or error, or where the participating Employee has recovered his lost wages from a third party, whether by judgment, settlement or otherwise.

GENERAL LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Individuals:

1. **Abortions:** Elective abortions are not covered.
2. **Administrative or Adjunctive Charges:** Charges for: administrative fees; completion, filing or copying of claim forms, itemized bills and/or medical reports; reports or appearances in connection with legal proceedings, whether or not an Illness or Injury is involved, mailing, postage, or shipping and handling; missed appointments; late fees; sales tax; interest or penalties; travel time or expenses; telephone consultations; communications.
3. **Alcohol/Substance Abuse:** No compensation of any kind shall be paid for any Injury or death substantially related to the intentional use or abuse, by the Covered Individual, of alcohol, controlled substances or chemicals. The use or abuse of alcohol, controlled substances or chemicals shall be deemed substantially related to injury or death if a) objective testing of the breath, blood or urine of the covered member demonstrates the use or abuse of alcohol, controlled substances or chemicals and any competent evidence establishes that it is more probable than not that the use or abuse of alcohol, controlled substances or chemicals contributed to the occurrence of the accident that caused the Injury or death to the covered member; or b) such use or abuse of alcohol, controlled substances or chemicals by the covered member resulting in criminal conviction by any lawful jurisdiction.
4. **Artificial Heart:** Charges related to insertion or maintenance of an artificial heart.
5. **Autopsy:** Charges for an autopsy.
6. **Birthing Classes:** Charges for birthing classes.
7. **Chelation Therapy:** Charges for chelation or metallic ion ion therapy, except for treatment of acute metal poisoning.
8. **Close Relative:** Charges for services rendered by a close relative of the covered person.
9. **Cosmetic and Reconstructive:** Charges for cosmetic and reconstructive procedures, except as specifically stated in the "Covered Medical Expenses" section of this Plan.
10. **Counseling:** Charges for marriage, bereavement, family, or group counseling.
11. **Court-ordered Treatment or Services:** Charges for services, treatment or care of any kind that are provided due to a court order, or are required by a court order, or are required by a court of law and/or are imposed as an alternative to, or in addition to, fine or imprisonment. This exclusion shall not apply to expenses for the Illness or Injury that would be covered under the Plan in the absence of a court order, and for which the covered person is legally obligated to pay.
12. **Custodial Care:** Charges for services or supplies provided mainly as custodial care, to assist in the activities of daily living, or maintenance care no expected to improve the patient's medical condition.
13. **Dental Care:** Charges for dental services including dental implantology, except as specifically indicated as a covered medical expense under this Plan.

14. Deluxe or Luxury items: Charges for deluxe or luxury items: examples are motorized equipment when manually operated equipment can be used, wheelchair sidecars. The Plan will cover deluxe equipment only when additional features are required for effective medical treatment, or to allow the covered person to operate the equipment without assistance.

15. Education or Vocational Services or Supplies: Charges for education or vocational testing and/or training, I.Q. tests, remedial reading, recreational therapy, vision therapy, behavioral modification therapy services or supplies, including, but not limited to personal computers and related equipment or other similar items or equipment. This exclusion does not include diabetic education and supplies specifically listed as covered medical expenses of this Plan.

16. Examinations: Charges for examinations, testing, vaccinations or other services related to employment, licensing, insurance, adoption, marriage license, sports, or camp applications, or travel outside of the United States.

17. Excess Charges: Charges for the part of an expense for treatment of an Injury or Illness performed by an Out-of-Network provider, the portion of a charge that is in excess of Usual, Customary and Reasonable charges.

18. Experimental or investigational: Charges for Experimental procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States or not recognized by the American Medical Association or the American College of Surgeons and/or the United States Food & Drug Administration. Experimental services include:

    a. Care, procedures, treatment protocol or technology which:

        i. is not widely accepted as safe, effective and appropriate for the Injury or Illness throughout the recognized medical profession and established medical societies in the United States; or

        ii. is Experimental, in the research or investigational stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies.

    b. Drugs, tests, and technology which:

        i. the FDA has not approved for general use;

        ii. are considered Experimental;

        iii. are for investigational use; or

        iv. are approved for a specific medical condition but are applied to another condition. Medications and procedures that are FDA approved for one diagnosis, but used in an off label manner may be covered under the Plan if approved by the Medical Director of HealthCorp as being medically appropriate and necessary for the Covered Individual's condition, or have been proven in an objective manner to have therapeutic value.

    The Plan will rely on the Data project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, the Association of Community Cancer Centers (ACCC) compendia based drug bulletin, NCCN drug compendia, Office of Health Technology Assessment, the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, and Congressional Office of Technology Assessment in determining Experimental services

19. Eye Care: Charges for routine eye exams and glasses or contacts, except as described in the options Vision Care Expense Benefits. Charges in relation to radial keratotomy, corneal modulation, refractive keratoplasty or any similar procedure. Reversals or revisions of surgical procedures that alter the refractive character of the eye and complications of such procedures, except when required to correct an immediately life-threatening condition. Charges for eye exercises (vision therapy) or training (orthoptics).

20. Gender Dysphoria: Charges for or in connection with sex change for non-congenital transsexualism, gender dysphoria, sex reassignment or transformation. This Exclusion includes, but is not limited to medications, hormone therapy, implants, surgery, medical and/or psychiatric treatment.

21. Hair Loss: Charges for treatment of hair loss, including medications for hair growth, and hair replacement devices, including but not limited to wigs, hairpieces, and hair transplants.

22. Health Club: Charges for health club or health spa membership, aerobic and strength condition, work hardening programs, regardless of diagnosis or symptoms, and all related material and products for these programs.

23. Hearing Loss: Charges for hearing examinations and tests to determine the need for hearing correction, hearing aids, tinnitus maskers, supplies, adjustments and repairs. A chochlear implantation (a device implanted in the ear to facilitate communication for the profoundly hearing impaired) will not be a covered expense.

24. Home Services: Charges for homemaker, and housekeeping services, or home delivered meals.

25. Hospital Admissions: Charges for Inpatient admissions that are primarily for diagnostic services or therapy services; or non-emergency weekend admission when surgery is not performed within 24 hours of admission; or inpatient admissions when the covered person is ambulatory and/or confined primarily for bed rest, special diet, or for treatment not requiring continuous bed care. Charges for hospitalization for dental services unless Medically Necessary to safeguard the health of the patient. Charges for services made by a Hospital for the covered person's failure to vacate a room on or before the Hospital's established discharge hour. Charges when a registered bed patient is absent from the Hospital.

26. Hospital Employee Charges: Charges for professional services billed by a physician or nurse who is an employee of the hospital or skilled nursing facility and paid by the hospital or facility for the service.

27. Illegal Act: Charges resulting from the commission of a crime.

28. Indian Health Services: In no event shall The Eastern Shoshone Tribe Employee Benefit Plan be liable for expenses or reimbursement for medical, surgical, hospital or related services to which the insured member is entitled to receive from or through the United States Public Health Service or any federally funded or sponsored Indian Health Service program. However this exclusion does not apply to referrals if the patient will lose life, limb or vision within 72 hours.

29. Ineligible Claims: Claims for charges incurred prior to the effective date of the patient's coverage under this Plan, or after coverage has terminated. Claims or other required information submitted to the Plan after the Plan's claims filing deadline. Under this Plan, a charge is considered to have been incurred as of the date on which the service is rendered or obtained.

30. Infant Formulas: Charges for infant formulas.

31. Infertility/Fertility/Sterility: Charges for infertility diagnosis and treatment (including medications), fertilization, artificial insemination, invitro fertilization, any treatment to promote conception and related tests/procedures; supplies, or treatment including drugs related to sexual dysfunction or inadequacy.

32. Impotency: Charges incurred for the treatment of impotency, erectile dysfunction, sexual dysfunction or inadequacy, or frigidity, including but not limited to, penile prosthetic implants, devices, drugs, and medicines, whether or not medically necessary or following surgery.

33. Maintenance Care: Medical care that according to accepted medical standards cannot reasonably be expected to contribute substantially to improvement of a medical condition in custodial care.

34. Marijuana: Charges for the purchase or use of marijuana for medicinal purposes.

35. Medical Research: Charges for examinations and treatment conducted for the purpose of medical research.

36. Native Healing Ceremonies: Charges for Native Healing Ceremonies.

37. No Obligation to Pay: Charges for services or supplies for which there is no legal obligation to pay, or charges that would not be made but for the availability of benefits under the Plan. Any portion of the billed charges for services or supplies that are waived by the provider, such as those portions that would not be paid by the Plan due to Deductible and/or Coinsurance provisions.

38. Non-covered Services or Supplies: Charges for services rendered as a result of (or due to any complications arising from): (1) any voluntary or elective surgery or treatment not incident to an Illness or Injury (unless specifically included as a Covered Expense in this Plan), or (2) ay surgery, services, treatment, or supplies specifically excluded from coverage under this Plan. Charges for any services or supplies not listed as Eligible Expenses in this Plan.

39. Non-prescription Drugs. Medicines or Supplies: Except as specified as Covered Medical Expenses under the Plan, regardless of the relief they may provide for medical condition, charges for drugs, medicines, or supplies that do not require a physician's prescription are not covered, even if recommended or ordered by a physician, and even if a prescription number has been assigned, when a written prescription is not required in order to purchase the drug, medicine or supply.

    This exclusion includes, but is no necessarily limited to the following: Air conditioners, blood pressure instruments, breast pumps, electric beds, environmental control or enhancement, exercise equipment, filters, flotation mattresses, heating lamps, heating pads, hot water bottles, humidifiers, hypoallergenic mattresses, items for activities of daily living, lift or control chairs, motor vehicles, motor vehicle devices such as hand controls, lifts or specialized vehicle alterations, non-implantable communication-assist devices (including but not limited to communication boards and computers), other clothing and equipment that is not medical in nature, pillows, purifiers, saunas, self-help devices, spas, steam baths, stethoscopes, swimming pools, thermometers, vacuum cleaners, vaporizers, vibrating chairs or beds, vitamins, waterbeds, or whirlpools.

40. Not Medically Necessary: Charges for services that are not Medically Necessary for the diagnosis and/or treatment of an illness or injury, unless specifically shown as an Eligible Expense elsewhere in the Plan.

41. Occupational Illness or Injury: Charges for or in connection with Injury or Illness that results form or in the course of a covered person's regular occupation for wage or profit and/or for which a covered person is entitled to benefits under any Workers' Compensation, Plan Administrator's Liability, or similar law. The covered person must promptly claim and notify the Plan Administrator of all such benefits. This limitation will not exclude coverage for self-employed individuals who are not required by the state to purchase work comp coverage.

42. Orthognathic Surgery: Charges for mandibular or maxillofacial surgery (orthognathic surgery) for treatment to correct growth defects, jaw disproportion, or malocclusion.

43. Outside the USA: Charges incurred outside the United States of America if the covered person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

44. Personal Items: Charges for personal comfort items or equipment, or for services or supplies that constitute personal hygiene items or personal convenience, such as telephone, and television or radio use.

45. Public or Private School Items: Charges for examinations, or consultations provided by any public school or halfway house, or by employees thereof, or services or items any school system requires and is provided solely to satisfy institutional requirements.

46. Self-inflicted Injury: Injury or Illness caused or contributed to by attempted suicide or intentionally self-inflicted injury, unless the result of a medical condition, whether mental or physical.

47. Sleep Disorders: Charges for the diagnosis and/or treatment of sleep disorders, except for treatment of sleep apnea.

48. Smoking Cessation: Charges for prescription and non-prescription smoking deterrent medications, gum, patches, and aids. Charges for smoking/nicotine/tobacco deterrent programs.

49. Special Construction: Charges for wheelchair ramps, handrails, or other specialized structural construction in or around the covered person's residence.

50. Sterilization Reversal: Care and treatment for reversal of sterilization.

51. Supplements: Charges for supplements including but not limited to mineral, nutritional, dietary and vitamins. Prescription vitamins are covered under the Prescription Drug benefit.

52. TENS Unit: Charges for a transcutaneous electrical nerve stimulators (TENS) unit for nerve stimulation.

53. TMJ: Charges for treatment of or prevention of, any jaw problem not caused by documented organic disease or physical trauma, including temporomandibular joint dysfunction (TMJ), craniomaxillary or craniomandibular conditions of the joint linking the jaw bone to the skull, and the muscles, nerves and other tissues related to that joint, myofacial pain syndrome, and all related conditions, including orthodontic or prosthetic devices.

PRE-EXISTING CONDITIONS

Does not apply to prescriptions submitted through the Prescription Drug Expense Benefit

Does not apply to Covered Individuals under age 19

- For a Covered Individual who enrolls in this Plan within 31 days after the date of his eligibility for coverage, or for a Covered Individual who enrolls in the Plan under the Special Enrollment provision, claims in relation to or resulting from Pre-Existing Conditions (A disease, Injury, or Illness of a Covered Individual for which the Covered Individual has been under the care of a licensed Physician or has received medical care, services, or supplies within the three (3) month period immediately preceding: 1) for new hires, his date of employment; or 2) for Special Enrollees his enrollment date with the Company) will be excluded from coverage under the Plan until the Covered Individual: 1) for new hires, has been employed by the Company for a period of 12 consecutive months; or 2) for Special Enrollees, has been enrolled for coverage under the Plan for a period of 12 consecutive months, in which case the pre-existing conditions limitation will no longer apply, and all eligible charges incurred thereafter will be considered under the Plan.

- For a Covered Individual who enrolls in this Plan more than 31 days after the date of his eligibility for coverage, claims in relation to or resulting from Pre-Existing Conditions (A disease, Injury, or Illness, of a Covered Individual for which the Covered Individual has been under the care of a licensed Physician or has received medical care, services, or supplies within the three (3) month period immediately preceding his effective date of coverage) are excluded from coverage under the Plan until the Covered Individual has been enrolled under the Plan for a period of 18 consecutive months, in which case the pre-existing conditions limitation will no longer apply, and all eligible charges incurred thereafter will be considered under the Plan.

- Exceptions to the Pre-Existing Condition Limitation:

  1. The Plan's pre-existing condition exclusion does not apply to pregnancy or to Covered Individuals up to age 19. The Pre-existing condition exclusion does not apply to Employees or covered Dependents who are returning from a leave which qualifies under the Family and Medical Leave Act (FMLA) and chose not to retain coverage under the Plan during the leave.

  2. The Pre-Existing Condition Limitation will be waived wholly or in part in the event an individual was insured previously by Creditable Coverage, and providing the break in such coverage was less than 63 days immediately prior to: 1) for new hires, his date of employment; or 2) for Special and Late Enrollees, the date of enrollment in this Plan. Any time periods used to satisfy the individual's Pre-Existing Condition Limitation under the prior plan will be credited towards the satisfaction of this Plan's Pre-Existing Conditions Limitation, to the extent that such time was satisfied under the prior plan.

For the purposes of this Plan, "Creditable Coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

b. A group health plan as defined in 2590.732(a);

c. Health insurance coverage as defined in 2590.701-2;

d. An individual health plan;

e. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);

f. Chapter 55 of Title 10, United States Code (military-sponsored health care);

54. Training and Therapies: Unless specifically listed as a covered elsewhere in this Plan, charges incurred for treatment, testing, procedures, devices, drugs, therapy, counseling and training and self-help programs.

55. War: Charges that result from the covered person being drafted or willing participation in war or any act of war (declared or undeclared) including armed aggression resisted by the forces of any country or combination of countries, or civil war, insurrection, rebellion, revolution or a riot or caused by service in the armed forces of any country.

56. Weight Control: Charges for weight control or diet, obesity, including morbid obesity, regardless of the adjunctive, medical or psychological condition. Expenses for treatment, surgery, supplies, instruction, or activities for weight control, weight reduction, weight loss programs, or physical fitness, vitamins, diet supplements, recreational therapy, education therapy, non-medical self-care or self-help training, or enrollment in a health, athletic, or similar club, even if the covered person has other health conditions which might be helped by weight loss or reduction of obesity and the services are performed or prescribed by a physician.

CREDITABLE COVERAGE

Acceptance of Certificates

Any Pre-existing Condition limitation period is reduced by the period of other Creditable Coverage unless there has been a lapse in coverage of 63 days or more, termed a Break in Coverage. Waiting periods and HMO affiliation periods are not considered a lapse in coverage. Days of Creditable Coverage that occur before a Break in Coverage shall not be counted by the Plan in reducing the Pre-existing Condition limitation.

Creditable Coverage includes coverage under most individual and group health insurance plans (including Medicare, Medicaid, governmental and church plans) whether or not a fully insured plan or a self-insured plan. Creditable coverage does not include liability, dental, vision, specified diseases and/or other supplemental type plans, which are defined as excepted benefits by HIPAA.

To reduce a Pre-existing Condition limitation period by creditable coverage, proof of prior creditable coverage must be submitted. A Participant may request a Certificate of Coverage from his prior plan. The Employer will assist any Participant in obtaining a Certificate of Coverage from a prior plan.

Within a reasonable time following the receipt of a Certificate of Creditable Coverage or other evidence of Creditable Coverage, the Plan shall make a determination regarding the length, if any, of the Pre-existing Condition limitation that shall apply to the Participant and provide notice to the Participant of said determination. The Plan shall have the right to reconsider and modify its initial determination if it is later determined that the claimed Creditable Coverage did not exist.

The Plan shall determine the total days of creditable coverage for each Participant by counting all the days during which the Participant had one or more types of Creditable Coverage. This determination will be made regardless of the specific benefits included in the coverage.

If, after creditable coverage has been taken into account, there will be a Pre-existing Condition limitation imposed on a Participant, that Participant will be notified.

Provision of Certificates

The Plan shall issue a Certificate of Creditable Coverage, automatically and without charge, under the following circumstances:

1. For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage; the Certificate of Creditable Coverage shall be issued after the Qualifying Event.
2. For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate of Creditable Coverage shall be issued as soon as reasonably possible after coverage ceases.
3. For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate of Creditable Coverage shall be issued within a reasonable time after the cessation of COBRA coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

g. A State health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code (the Federal Employees Health Benefits Program);

i. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

j. A medical care program of the Indian Health Service or of a tribal organization;

k. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or

l. Title XXI of the Social Security Act (State Children's Health Insurance Programs (S-CHIP).

The Plan shall also issue a Certificate of Creditable Coverage at any time within twenty-four (24) months after coverage ceases, provided that the Plan receives a written request for the Certificate of Creditable Coverage by the former Plan Participant (or by another person authorized by the former Plan Participant). A Certificate of Creditable Coverage may be obtained from the Claims Administrator by contacting them at the following address:

Self Insured Services Company
P.O. Box 389
Dubuque, IA 52004-0389
800-457-4726

The Certificate of Creditable Coverage shall be in the form required by HIPAA.

Also upon written request, the Plan shall provide a copy of the Plan Document and other information as outlined in the model form established by HIPAA to provide additional information on categories of benefits for plans that use the Alternative Method of counting Creditable Coverage.

ELIGIBILITY FOR COVERAGE

Employee Eligibility and Effective Date

An Employee is eligible for coverage under the Plan when the Employee:

1. Is employed by the Company on a regular, Full-Time Work basis as specified in the Plan Summary;
2. Is Actively at Work;
3. Has satisfied the Required Period of Service as specified in the Plan Summary; and
4. Is within the classification (if any) shown in the Plan Summary.

If the Employee has met the above eligibility requirements on or before the effective date of this Plan, the date of eligibility shall be the effective date of the Plan.

If the Employee meets the above eligibility requirements after the effective date of the Plan, the date of eligibility shall be the first day of the month following the day he first meets those eligibility requirements.

Employee Coverage under the Plan shall become effective on the date of the Employee's eligibility, provided he has made written application for such coverage on or before such date. If an Employee applies for coverage within 31 days after his date of eligibility, his coverage shall be retroactive to the initial date of eligibility.

All Employee Coverage under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective, provided such Employee is able to be actively at work at such time. If the Employee is not Actively at Work on the date this Employee Coverage would otherwise take effect, but would have been able to be Actively at Work at 12:01 A.M. Standard Time had such work commenced at that time, such Employee shall be eligible for coverage on that date. If an eligible Employee is not able to be Actively at Work on the date this Employee Coverage would otherwise become effective, his coverage shall become effective on the day he returns to Active Work except as required by HIPAA.

If an individual who works for the Company part-time is promoted to Full-Time Work, he will be given credit toward the Required Period of Service for any time satisfied as a part-time Employee (does not include temp employees). All other provisions of this Plan shall apply.

An Employee who chooses not to keep his coverage in effect during a period of layoff will be eligible to enroll for the same type of coverage (single or Family) which was in effect at the time of the layoff immediately upon return to Full-Time work provided he returns to Full-Time work within 30 days of the date the layoff began.

An Employee who chooses not to keep his coverage in effect during a period of an approved leave of absence which qualifies under the Family and Medical Leave Act will be eligible to enroll for the same type of coverage (single or Family) which was in effect at the time of the leave of absence immediately upon return to Full-Time Work.

Each Employee will become eligible for Dependent Coverage on the latest of the following:

1. The date he becomes eligible for Employee coverage.
2. The date on which he first acquires a Dependent.
3. The date he first comes within the classification (if any) for Dependent Coverage, as stated in the Plan Summary.

If both the husband and wife are employed by the Company and both are eligible for Dependent Coverage, either the husband or wife, but not both, may elect Dependent Coverage for their eligible dependents.

Dependent Eligibility and Effective Date

A Dependent will be considered eligible for coverage on the date the Employee becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan. Each Employee who makes such written request for Dependent Coverage on a form approved by the Company, shall, subject to the further provisions of this section, become covered for Dependent Coverage as follows:

1. If the Employee makes such written request on or before the date he becomes eligible for Dependent Coverage, or within the time frame listed in "Employee Eligibility" to enroll, he shall become covered, with respect to those persons who are then his dependents, on the date he becomes covered for Employee Coverage.
2. A Newborn child of an Employee will be covered from the moment of birth providing proper enrollment is completed within 31 days of the child's birth.
3. An adoptive child of an Employee or a child placed with the Employee for adoption will be covered from the date the child is placed in the physical custody of the Employee and the Employee is legally responsible for medical expenses incurred by said child if proper enrollment is completed within 31 days of the placement.
4. If a Dependent is acquired other than at the time of his birth due to a court order, decree, or marriage, coverage for this new Dependent will be effective on the date of such court order, decree, or marriage if Dependent Coverage is in effect under the Plan at that time and proper enrollment is completed within 31 days of the event. If the Employee does not have Dependent Coverage in effect under the Plan at the time of the court order, decree, or marriage and requests such coverage and properly enrolls this new Dependent within the 31 day period immediately following the date of the court order, decree, or marriage, Dependent Coverage will be retroactive to the date of the court order, decree, or marriage.

LATE ENROLLMENT

Enrollment for coverage is required within 31 days after the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a covered Employee's and/or Dependent's coverage terminates because of failure to make a contribution when due, such person will be considered a late enrollee. Some late enrollments may be made under the following Special Enrollment provision, however, if the Special Enrollment provisions do not apply, a late enrollee will only be eligible to enroll during the Annual enrollment period designated by the Company. The 18-month Pre-Existing Condition limitation of this Plan will apply to all late enrollees who do not qualify to enroll under the Special Enrollment provision.

Special Enrollment

Special enrollment rights may be triggered upon the occurrence of certain types of events as indicated below. When a triggering event occurs, an eligible individual who does not request enrollment in the Plan within the deadlines explained below, will lose special enrollment rights for that event.

1. **First Type of Event – Loss of Other Health Coverage**

   Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it because of other health coverage, which they stated in writing was in place, are entitled to enroll in the plan when the other coverage ends.

   Other Coverage is COBRA Coverage. If the other coverage is COBRA coverage, the eligible Employee or Dependent must exhaust COBRA coverage to be eligible for special enrollment in the Plan. Exhaustion of COBRA coverage means that COBRA coverage ends for any reason other than failure to pay contributions on time or for cause.

   Other Coverage is Not COBRA Coverage. If the other coverage is not COBRA coverage, the Employee or Dependent must lose the other coverage as a result of loss of eligibility for the coverage, termination of employment, exceeding a Lifetime limit on benefits under the other coverage, or termination of the employer contribution toward the other coverage. If an individual loses coverage due to ceasing to make required premium payments when due, he will not qualify as a special enrollee.

   Deadline for Special Enrollment Period. The eligible Employee is required to request special enrollment in the Plan not later than 31 days after the loss of the other coverage or the termination of employer contributions toward that other coverage. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and/or Dependent lose special enrollment rights for that event.

   Effective Date of Enrollment. Enrollment in the Plan under the Special Enrollment provision will be effective not later than the first day of the first calendar month beginning after the date the Plan Administrator receives your completed request for enrollment.

2. Second Type of Event – Addition of a Dependent

An eligible Employee's marriage, or the birth, adoption or placement for adoption of his or her child, triggers special enrollment rights. This type of event also triggers an opportunity for an Employee who is enrolled in a Company sponsored Plan to switch to another Company sponsored Plan, if the Company has multiple Plans available.

Non-Participating Employee May Also Enroll. The addition of a new Dependent triggers enrollment rights for an eligible Employee even if he or she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible Employee's child, the eligible Employee (assuming that he or she did not previously enroll), his or her spouse, and his or her Newborn child may all enroll because of the child's birth. The same rule applies to the eligible Employee's marriage or adoption of a child or a child's placement for adoption if the eligible Employee had not previously enrolled in the Plan.

Deadline for Special Enrollment Period. An eligible Employee must request special enrollment within 31 days of marriage, or birth, adoption or placement for adoption of his or her child. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, he or his Dependents lose special enrollment rights for that event.

Effective Date of Enrollment. The date of enrollment for coverage will be the date of the event in the case of birth, adoption or placement for adoption and not later than the first day of the first calendar month after the marriage occurs, and provided the Plan Administrator receives the enrollment form.

3. Third Type of Event – Loss of Medicaid or CHIP Coverage

Eligible Employees and their eligible Dependents whose Medicaid or CHIP (Children's Health Insurance Program) coverage terminates due to loss of eligibility are entitled to enroll in the Plan when the Medicaid/CHIP coverage ends.

Eligibility for Premium Assistance Subsidy Under Medicaid or CHIP. Eligible Employees and their Dependents, who become eligible for a premium assistance subsidy under Medicaid or CHIP, are entitled to enroll in the Plan when they become eligible for the premium assistance subsidy.

Deadline for Special Enrollment Period. The eligible Employee is required to request special enrollment in the Plan not later than 60 days after the loss of Medicaid/CHIP coverage or becoming eligible for the premium assistance subsidy. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and/or Dependent lose special enrollment rights for that event.

Effective Date of Enrollment. Enrollment in the Plan under the Special Enrollment provision will be effective not later than the first day of the first calendar month beginning after the date the Plan Administrator receives your completed request for enrollment.

Pre-existing Condition Exclusion and Special Enrollees. The Plan will apply a Pre-Existing Condition exclusion period of 12 months to a special enrollee. The Plan will not apply a Pre-Existing Condition exclusion to Pregnancy or to Covered Individuals under age 19.

TERMINATION OF COVERAGE

Employee Termination

Employee Coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The last day of the month in which the Employee terminates employment.
2. The last day of the month in which the Employee ceases to be in a class of participants eligible for coverage.
3. The date ending the period for which the last contribution is made if the Employee fails to make any required contributions when due.
4. The date the Plan is terminated; or with respect to any Employee benefit of the Plan, the date of termination of such benefit.
5. The date the Employee enters military duty.
6. The date of the Employee's death.

Dependent Termination

Dependent Coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan.
2. The date of termination of the Employee's coverage under the Plan.
3. The last day of the month in which the Employee ceases to be in a class of participants eligible for Dependent Coverage.
4. The date ending the period for which the last contribution is made if the Employee fails to make any required contributions when due.
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit.
6. The date the Dependent spouse enters military duty.
7. The date the Dependent becomes covered under this Plan as an Employee.
8. The last day of the month in which the Employee's death occurs.

EXTENSION OF BENEFITS

Family and Medical Leave Act Provision

All provisions under the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Company, Plan benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Company and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An Employee with questions concerning any rights and/or obligations should contact the Company.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

It is the intent of the Plan to adhere to the continuation of coverage provisions of The Uniformed Services Employment and Reemployment Rights Act (USERRA) effective October 14, 1994. Any Plan provisions which conflict with USERRA are superceded by USERRA. An individual who would like complete information regarding his rights under USERRA should contact the Plan Administrator.

Extension for Child Care Workers

Employees who work regularly scheduled hours during the school year will be eligible to continue coverage during summer break or any regularly scheduled school break, provided required contributions for coverage are paid when due.

COBRA Extension of Benefits

The requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to the Plan. If Plan coverage is discontinued because of any of the qualifying events described below, eligible Covered Individuals may elect continuation coverage under the Plan according to the COBRA rules.

A. Qualifying Events

An employee of the Company covered by the Plan, has the right to choose this continuation coverage if such employee loses group health coverage because of a reduction in such employee's hours of employment or the termination of such employee's employment (for reasons other than gross misconduct).

The spouse of an employee covered by the Plan, has the right to choose continuation coverage if such spouse loses group health coverage under the plan for any of the following reasons:

1. The death of the covered employee;
2. The termination of the covered employee's employment (for reasons other than gross misconduct) or reduction in the covered employee's hours of employment;
3. Divorce or legal separation from the covered employee;
4. The covered employee becomes entitled to Medicare; or
5. A proceeding in a case under Title 11, United States Code, with respect to the Company from whose employment the covered employee retired.

In the case of a dependent child of an employee covered by the Plan, the dependent child has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

1. The death of the covered employee;
2. The termination of the covered employee's employment (for reasons other than gross misconduct) or reduction in the covered employee's hours of employment;
3. The covered employee's divorce or legal separation;
4. The covered employee becomes entitled to Medicare;
5. The dependent cease to be a "dependent child" as defined under the Plan; or
6. A proceeding in a case under Title 11, United States Code, with respect to the Company from whose employment the covered employee retired.

B. Important Notice Requirements

Under the law, the employee or an eligible dependent has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the later of: 1) the date the qualifying event occurs; 2) the date coverage is lost; or 3) the date the beneficiary is notified – through the Summary Plan Description (SPD) or the general COBRA notice. Such notice must be in writing to the Director of Human Resources, and contain the name of the Covered Individuals affected by the event and the date and nature of the event. The Company has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement, no later than 30 days after the date the Employee loses coverage due to the qualifying event.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will ensure that the employee and the employee's eligible covered dependents are notified within 14 days of the right to choose continuation coverage. Under the law, the employee and eligible covered dependents have 60 days from the later of: the date the employee or his eligible covered dependent(s) would lose coverage because of one of the events described above or the date the employee or his eligible covered dependent(s) are advised by the Plan Administrator of the right to continue coverage, to inform the Plan Administrator that the employee and/or the eligible covered dependents want continuation coverage.

Notice to the employee's eligible covered spouse of the right to elect continuation coverage under the Plan will be deemed notice to any eligible covered dependent children residing with the employee's spouse. If the employee or his eligible covered dependent(s) do not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost.

An eligible employee may elect COBRA continuation coverage for an eligible child who is born to, or placed for adoption with such employee while the employee's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the employee has notified the Plan Administrator in writing within 30 days of the child's birth, adoption or placement for adoption.

C. Payment for Continuation Coverage

The employee and his eligible covered dependent(s) will be required to pay for the cost of continuation coverage in an amount equal to the cost of Plan coverage, plus 2%. The contributions must be paid by a check made payable to the Company.

Contribution amounts and benefits for continuation coverage are subject to change. The employee will be notified of any changes in contribution amounts or benefits available under the Plan.

If the employee or his eligible covered dependent(s) elect continuation coverage after the qualifying event, then the employee or his eligible covered dependent(s) will have 45 days from the date of the election to make the required initial contribution. That initial contribution must cover the entire period from the date of the qualifying event to the date of the payment. There is no grace period for the initial contribution. Each other contribution payment is due within 30 days after the first day of each month of continuation coverage.

Covered Individuals will not be billed for any contribution payments for continuation coverage. If any contribution payment for continuation coverage is postmarked after the date that payment is due, continuation coverage under the Plan will terminate and will not be reinstated.

D. Length of Continuation Coverage

If the employee and/or his eligible covered dependents elect to continue Plan coverage, the maximum continuation period following a qualifying event involving termination of employment or reduced work hours is 18 months.

If the employee or his eligible covered dependent is found by the Social Security Administration (SSA) to be eligible for Social Security disability benefits because of a disability that existed at some time during the first 60 days of this COBRA continuation coverage, then the disabled person and his eligible covered dependents will be eligible to continue Plan coverage for up to 29 months (an additional 11 months). To be eligible for that additional time to continue Plan coverage, the disabled person must remain disabled and must notify the Plan Administrator of the Social Security determination, in writing, by supplying a copy of the SSI award letter within the initial 18-month period and within 60 days after the later of:

- The date of the Social Security disability determination;
- The date of the qualifying event;
- The date on which coverage is lost as a result of the qualifying event, and
- The date on which the beneficiary is informed (in the Summary Plan Description or general notice) about the obligation to provide the disability notice.

An increased cost of up to 150% of the cost of the Plan coverage may be required for those 11 extra months of continuation coverage. The disabled person must promptly notify the Plan Administrator of any SSA finding that he or she is no longer disabled.

If a second qualifying event occurs within the applicable 18- or 29-month period, the period to continue Plan coverage under COBRA may be extended for up to 36 months from the first qualifying event. For all other qualifying events, the maximum period to continue Plan coverage is 36 months.

E. Termination of Continuation Coverage

However, COBRA provides that this continuation coverage may be cut short for any of the following reasons:

1. The Company no longer provides group health coverage to any of its employees;
2. The premium for this continuation coverage is not paid on time;
3. The employee or his eligible covered dependent(s) become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition such individuals may have or contains a pre-existing condition exclusion that does not apply to such individuals because of the requirements of the Health Insurance Portability and Accountability Act of 1996;
4. The employee or his eligible covered dependent(s) become entitled to Medicare; or

5. The employee or his eligible covered dependent(s) elected to extend coverage for up to 29 months due to disability and there has been a final determination by the SSA that such individual is no longer disabled.

The employee or his eligible covered dependent(s) must inform the Plan Administrator within 30 days of the date of any final determination by the SSA that the person is no longer disabled.

F. General Information about Continuation Coverage

Continuation coverage is provided subject to eligibility under the law. The Plan Administrator reserves the right to terminate continuation coverage retroactively if the employee or his dependent(s) are determined to be ineligible for continuation coverage. The Plan Administrator intends to provide continuation coverage only to the extent required by the law and will administer continuation coverage according to those requirements.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records of any notices you send to the Plan Administrator.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Allowable Expenses. It applies when the Employee or any eligible Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment.

All benefits contained in the Plan are subject to this provision.

Definitions

The term "plan" as used herein will mean any plan providing benefits or services for or by reason of medical, vision, or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Individuals in a group whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits.
    b. Hospital reimbursement-type plans which permit the Covered Individual to elect indemnity at the time of claims.
2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans.
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.
4. A licensed Health Maintenance Organization (HMO).
5. Any coverage for students which is sponsored by or provided through a school or other educational institution.
6. Any coverage under a governmental program, and any coverage required or provided by any statute.
7. Group automobile insurance.
8. Individual automobile insurance coverage on an automobile leased or owned by the Company.
9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term "Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Individual for whom claim is made has been covered under this Plan.

Coordination Procedures

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total of Allowable Expenses incurred during any Claim Determination Period with respect to a Covered Individual eligible for:

1. Benefits either as an insured person or participant or as a dependent under any other plan which has no provision similar in effect to this provision, or
2. Dependent benefits under this Plan for a Covered Individual who is also eligible for benefits:
   a. As an insured person or participant under any other plan, or
   b. As a dependent covered under another group plan.
3. Benefits under this Plan for a Employee who is also eligible for benefits as an insured person or participant under any other plan and has been covered continuously for a longer period of time under such other plan, or
4. If an eligible Dependent elects membership in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to copayment and/or Deductibles not covered under the HMO and Eligible Expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the Dependent chose not to avail himself to the HMO participating provider.

Order of Benefit Determination

In no event will The Eastern Shoshone Tribe Health Plan be liable for expenses or reimbursement for medical, surgical, Hospital or related services to which the Covered Individual is entitled to receive from or through the United States Public Health Service or any federally funded or sponsored Indian Health Service Program.

Each plan makes its claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for coordination of benefits, then it pays before all other plans.
2. The plan which covers the claimant as an employee or named insured pays as though no other plan existed; remaining recognized charges are paid under a plan which covers the claimant as a dependent.
3. If the claimant is a dependent child of parents not separated or divorced, the plan of the parent whose birthday occurs first in the Calendar Year shall pay first. If the parents have the same birthday, the plan that covered the parent longer will pay first and the other plan will pay second. This rule also applies to unmarried parents who are living together. However, if the parents are divorced, or unmarried and not living together, then:
   a. The plan of the parent who by court order or decree is financially responsible for the children's medical costs is primary.
   b. If no decree exists, the plan of the parent who has custody pays first;
   c. The plan of any stepparent with whom the child lives pays second;
   d. The plan of the parent without custody pays third.

   If the specific terms of a court decree state that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above for dependent children of parents not separated or divorced.

For purposes of this sub-section, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

4. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
5. If the order set out above does not apply in a particular case, then the plan which has covered the claimant for the longest period of time will pay first.

The Company has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant's consent.
2. To require that the claimant provide the Company with information on such other plans so that this provision may be implemented.
3. To pay the amount due under this Plan to an insurer or other organization if this is necessary, in the Company's opinion, to satisfy the terms of this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Company will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Company will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

Right To Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of the Plan or any similar provision of any other plans, the Company may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Company deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Company such information as may be necessary to implement this provision.

Coordination of Benefits with Medicare

In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each person that is eligible for Medicare will be assumed to have full Medicare coverage. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full Medicare coverage will be assumed whether or not it has been taken. Benefits under this Plan are subject to the allowable limiting charges set by Medicare. Benefits will be coordinated to the extent they would have been paid under Medicare as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Statement of Purpose

Subrogation and reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and reimbursement recoveries are used to pay future claims incurred by Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

The Plan Administrator has sole discretion to determine whether expenses are related to the Illness or Injury to the extent this provision applies. Acceptance of benefits under the Plan for an Illness or Injury which the Plan Participant(s) has already received a recovery may be considered fraud, and the Plan Participant(s) will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate, including denial of present or future benefits under the Plan.

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In certain circumstances, a Plan Participant(s) his or her attorney, and/or legal guardian of a minor or incapacitated individual may receive a recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the Illness or Injury that is the subject of the recovery. In other situations, a Plan Participant(s) may have received a prior recovery that was intended, in part or in whole, to be compensation for future expenses for treatment of the Illness or Injury that is the subject of a current claim for benefits under the Plan. In these situations, the Plan will not provide benefits for any present or future expenses related to the Illness or Injury for which compensation was provided through a current or previous recovery. The Plan Participant(s) is required to submit full and complete documentation of any such recovery in order for the Plan to consider Eligible Expenses that exceed the recovery. To the extent a Plan Participant(s)'s recovery exceeds the amount of the Plan's lien, the Plan is entitled to a credit or cushion in that amount against any claims for future benefits relating to the Illness or Injury. In those situations following any recovery that exceeds the amount of the Plan's lien, the Plan Participant(s) will be solely responsible for payment of medical bills related to the Illness or Injury out of the remaining recovery. If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's

attempt to recover such money. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

If the Plan Participant(s) retains an attorney, the Plan Administrator may require that attorney to sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Plan Participant(s)'s attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of recovery. The Plan will not pay the Plan Participant(s)'s attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the Plan Participant(s)'s attorneys' fees and costs.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. As a possessor of a portion of the recovery, the Plan Participant(s)'s attorney holds the recovery as a constructive trustee and fiduciary and is obligated to tender the recovery immediately over to the Plan. A Plan Participant(s)'s attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the Plan Participant(s) nor the attorney is the rightful owner of the portion of the recovery subject to the Plan's lien.

Time of Payment of Benefits

The Plan may withhold benefits until such time that liability is determined

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

a) the responsible party, its insurer, or any other source on behalf of that party;
b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company; or,

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by any recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Excess Insurance

If at the time of Injury, Illness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

a) the responsible party, its insurer, or any other source on behalf of that party;
b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company or
e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of the injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) to provide the Plan with pertinent information regarding the Illness, Injury, disease, disability, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

If the Plan Participant(s) and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness, or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

Failure by the Plan Participant(s) and/or their attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies their obligation.

Minor Status

In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

RIGHTS UNDER ERISA

Although the Eastern Shoshone Tribe health plan is not governed by ERISA, the Company is voluntarily guide by ERISA provisions as applicable to its government plans. Accordingly, interpretations of the Plan, including words and phrases, shall be guided by ERISA as applicable to government plans.

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of any Pre-Existing Condition exclusion under this group health Plan, if you have creditable coverage from another plan. You should be given a certificate of creditable coverage, free of charge, by the group health plan or health insurance issuer you lose coverage under. The certificate of creditable coverage should be given to you when you lose coverage, become entitled to elect COBRA continuation coverage, and when COBRA continuation coverage ends. If you request it, a certificate of creditable coverage should also be given to you at any time during the 24 months after you lose coverage. Without proof of creditable coverage, you may be subject to a Pre-Existing Condition exclusion of up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plans money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PROVISIONS

Notice of Claim

Written notice of claim should be submitted to the Claims Administrator within 90 days after the occurrence. All claims must be filed within one (1) year of the event on which claim is based or payment will be denied. Written notice of claim given by or on behalf of the Covered Individual to the Claims Administrator, with information sufficient to identify the Covered Individual, will be considered notice.

Failure to furnish proof within the time provided in the Plan will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Claim Procedure

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different types of claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding the procedure, please contact the Claims Administrator.

There are three types of health claims: urgent care claims, pre-service claims, and post-service claims. Most claims are post-service claims which means a claim for a Plan benefit that is a request for payment under the Plan for covered medical services already received by the claimant. An urgent care claim is one for medical care or treatment where an untimely determination may jeopardize the life or health of the claimant. A pre-service claim means any claim for a benefit under this Plan where the Plan requires advance approval for obtaining medical care.

In the case of a post-service claim, the Claims Administrator will process your claims no later than 30 days after receiving it. An additional 15 days will be allowed in circumstances beyond the Plan's control, such as the need for additional information. You will be notified during the first 30 days of the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination.

If your post-service claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your claim be denied (in whole or in part), or if there is a reduction of benefits or charge amount, you (or your provider) may have your claim reviewed. To do so, a review must be requested within 180 days of the denial by writing to:

Patient Advocate
Self Insured Services Company
P.O. Box 389
Dubuque, IA 52004-0389

You should supply any additional pertinent documentation to support the appeal of the claim. Within 60 days after receipt of your request for review, you will receive a determination from the Claims Administrator.

For an urgent care claim, notification of benefit determination will be given within 72 hours after the Claims Administrator receives the claim. If there is insufficient information to make a determination, a request will be made for the additional information within 24 hours of receiving the claim. This request may be in writing or orally. The claimant will then have 48 hours to provide the missing information. After receiving the information or when 48 hours has passed, the Claims Administrator will respond orally or in writing as to the benefit determination. If an urgent care claim is denied, an appeal may be filed with the Plan Administrator within 180 days of the denial. This appeal may be orally or in writing. Upon receipt of the appeal, a claim determination must be made within 72 hours. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

You will receive notice of benefit determination for a pre-service care claim within 15 days of the Claims Administrator's receipt of the claim. An additional 15 days will be allowed in circumstances beyond the Plan's control, such as the need for additional information, and you will be notified within five (5) days of receipt of the claim as to the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination. If your pre-service care claim is denied, you may file a written appeal within 180 days of the denial. Upon receipt of the appeal, the Claims Administrator will have 30 days to make a benefit determination.

If the Plan has previously approved an ongoing course of treatment for a participant to be conducted over a period of time, any reduction or termination of that course of treatment will be deemed to be an adverse benefit determination. The Plan Administrator must then notify the claimant a sufficient time in advance of the reduction or termination to give the claimant time to obtain a review on appeal of the adverse termination before the benefit is reduced or terminated.

Disability Claims

The Claims Administrator will make a benefit determination for disability claims within 45 days of receipt of the claim. An extension of 30 days will be allowed provided that the need for extension is due to circumstances beyond the Claims Administrator control and the claimant is notified within the original 45 day time period. The claimant will have 45 days to provide the required information and the Claims Administrator will make a benefit determination within 15 days of receipt of the information. If your claim is denied, you may file a written appeal within 180 days of the denial. Upon receipt of the appeal, the Claims Administrator will have 45 days to make a final benefit determination.

Proof of Loss

The Plan Administrator will have the right and opportunity to have examined any individual whose Injury or Illness is the basis of a claim hereunder when and as often as it may reasonably require during the pendency of a claim, and also the right and opportunity to make an autopsy in case of death (where such autopsy is not forbidden by law).

Free Choice of Physician

The Covered Individual will have free choice of any legally qualified Physician or surgeon, and the Physician-patient relationship will be maintained.

Payment of Claims

All Plan benefits are payable to the provider of service, or subject to any written direction of the Employee. All or a portion of any payments provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Employee's option and unless the Employee requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the Hospital or person rendering such services; however, if any such benefit remains unpaid at the death of the Employee or if the participant is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Employee: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan will not be required to see the application of the money so paid.

Assignment

Benefits may not be assigned except by consent of the Company, other than to Eligible Providers and according to the provisions set forth in the Plan Document.

Rights of Recovery

Whenever payments have been made by the Company with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Company will have the right, exercisable alone and in its sole discretion, to recover such excess payments or to withhold payment of any future benefits to offset for such excess payments. The Plan has the right to recover these amounts through any legal or equitable remedy, including imposition of a constructive trust.

Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Legal Proceedings

No action at law or in equity will be brought to recover on the Plan until you have followed the Plan's claims procedures and exhausted the opportunities described under the Plan's claims procedures, nor will such action be brought at all unless brought within three (3) years of receiving the final review notice under the Plan's claims procedures.

Conformity with Governing Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Permitted and Required Uses of Protected Health Information

Protected Health Information (PHI) is individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium. PHI will only be released to the "Privacy Officials" appointed by the Company. A list of Privacy Officials may be obtained from the Company.

Your health Plan will only provide Protected Health Information to the Plan Sponsor upon receipt of certification that the Plan Sponsor will agree to:

1. Not use or disclose the PHI other than as permitted or required by the Plan Document or as required by law;
2. Ensure that agents and subcontractors to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions as the Plan Sponsor;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the group health Plan any PHI use or disclosure, of which it becomes aware, that violates the permitted uses or disclosures under HIPAA;
5. Make PHI available in accordance with HIPAA privacy regulation, 45 CFR 164.524;
6. Make PHI available for amendment and incorporate those amendments as required by HIPAA privacy regulation, 45 CFR 164.526;
7. Make information available to provide an accounting of disclosures as provided in HIPAA privacy regulation, 45 CFR 164.528;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of the Department of Health and Human Services;
9. If feasible, at termination of the relationship, return or destroy all PHI received from the group health plan, but if return or destruction is not feasible, limit further uses or disclosures to those purposes that make return or destruction of the information infeasible; and
10. Ensure adequate separation between employees who are authorized to use PHI and those who are not.

Any information supplied to the Plan Sponsor in order to process claims and claim payment will be kept confidential by all individuals within the Company who use this information in the normal course of business. These individuals will restrict access to and use of PHI by individuals other than for plan administration functions that the Plan Sponsor performs for the group health plan. Misuse or improper disclosure of PHI by any individual in the Company will result in disciplinary sanctions, which may include dismissal. The Company shall provide a mechanism for resolving issues of noncompliance. PHI will not be disclosed to a Plan Sponsor for employment-related activities or decisions or in connection with any other benefit plan of the Plan Sponsor.

HIPAA Security Provision

Where electronic Protected Health Information (PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. sect. 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and
4. Plan Sponsor shall report to the Plan any "Security Incidents" of which it becomes aware as described below ("Security Incidents" has the meaning set forth in 45 C.F.R. sect. 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system):
    a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any "Security Incident" that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic Protected Health Information; and
    b) Plan Sponsor shall report to the Plan any other "Security Incident" on an aggregate basis every quarter, or more frequently upon the Plan's request.

Time Limitation

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity is less than that permitted under the guidelines of ERISA and/or any federally mandated law, such limitation is hereby extended to agree with the minimum period permitted by such law.

Statements

All statements made by the Company or by a Covered Individual will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this Plan will be used in any contest to avoid or reduce the benefits provided by the Plan unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Individual.

Any Covered Individual who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Individual may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Miscellaneous

Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan.

Pronouns used in this Plan Document shall include both masculine and feminine gender unless the context indicates otherwise. Likewise, words used shall be construed as though they were in the plural or singular number, according to the context.

No failure to enforce any provision of this Plan will affect the Company's right thereafter to enforce such provision, nor will such failure affect the Company's right to enforce any other provision of this Plan.

If an inadvertent error should occur due to interpretation of mandated benefits, relevant laws and regulations before the final regulations are issued, the Plan, Plan Administrator, Agent for the Service of Legal Process, Trustee, Claims Administrator, and Company will be held harmless for such an error; and in no way will such an error be construed as a precedent-setting event.

Payment for expenses in relation to services which are generally accepted as cost-containment measures in large claim management cases that are not normally covered under this Plan will be reimbursable upon recommendation of the Claims Administrator and written approval by the Plan Administrator.

DEFINITIONS

Accidental Injury

A condition which is the result of bodily Injury caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; this incident must be of a sufficient departure from the claimant's normal and ordinary lifestyle or routine; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

Active Work/Actively at Work

An Employee is considered to be at active work or actively at work when performing, in the customary manner, all of the regular duties of his occupation with the Company. An Employee shall be deemed at active work or actively at work on each day of a regular paid vacation; or on a regular non-working day, provided he was Actively at Work on the last preceding regular working day. A Covered Individual will be considered to be Actively at Work if he is absent solely due to a health reason.

Ambulatory Surgical Center

An institution or facility, either free-standing or as part of a Hospital, with permanent facilities, equipped and operated for the primary purpose of performing Surgical Procedures and to which a patient is admitted to and discharged from within a 24 hour period.

Amendment

A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator

Annual

Periodic, based on a Calendar Year.

Benefit Percentage

That portion of Eligible Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual Deductible, which are to be paid by the Employee.

Benefit Period

A time period of one Calendar Year. Such benefit period will terminate on the last day of the one-year period so established.

Calendar Year

A period of time commencing on January 1 and ending on December 31 of the same given year.

Certified Counselor

An individual qualified by education, training, and experience to provide counseling in relation to emotional disorders, psychiatric conditions, or substance abuse.

Chemical Dependency Treatment Facility

A facility which provides treatment of alcoholism, chemical dependency or drug addiction. The facility must e licensed by the state in which it is located or by the federal government to provide the treatment.

Chiropractic Care

Services performed by a person trained and licensed to practice chiropractic medicine, provided those services are for the remedy of diseases or conditions, which the chiropractor is licensed to treat.

Claim Determination Period

A Calendar Year or that portion of a Calendar Year during which the individual for whom claim is made has been covered under this Plan.

Claims Processor

The person or firm employed by the Company to provide consulting services to the Company in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

Close Relative

The spouse, parent, brother, sister, child, or spouse's parent of the Covered Individual.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance

That figure shown as a percentage in the Plan Summary used to compute the amount of benefit payable when the Plan states that a percentage is payable.

Company

Eastern Shoshone Tribe

Confinement

A continuous stay in the Hospital(s) or Skilled Nursing Facility/Extended Care Facility or combination thereof, due to an Illness or Injury diagnosed by a Physician.

Co-Payment

Co-payment is the fixed dollar amount you pay each time you receive certain covered services. The co-payment does not apply toward the Annual Deductible or out-of-pocket maximum and continues to be taken after the out-of-pocket maximum is met.

Cosmetic Procedure

A procedure performed to:

- change the texture or appearance of the skin; or
- change the relative size or position of any part of the body;

when such surgery is performed primarily for psychological purposes or for improvement of appearance rather than for restoration or improvement of a bodily function.

Covered Individual

Any Employee or Dependent of an Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

Custodial Care

That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Individual, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Deductible

A specified dollar amount of Eligible Expenses which must be incurred during a Benefit Period before any other Eligible Expenses can be considered for payment according to the applicable Benefit Percentage.

DEFRA

The Deficit Reduction Act of 1984, as amended.

Dentist

An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be a Dentist when he performs any of the dental services described herein and is operating within the scope of his license.

Dependent

The term "Dependent" means:

A. The Employee's legal spouse who is a member of the opposite sex and a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.

B. Children up to age 26 as defined below.

1) Natural-born children.
2) Stepchildren.
3) Foster children.
4) Legally adopted children and children placed with you for adoption. Date of placement means the assumption and retention by a person of a legal obligation in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation.

C. Children who are required to be covered by reason of a Qualified Medical Child Support Order ("QMCSO"), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an Order qualifies as a QMCSO. You and your family members can obtain, without charge, a copy of such procedures from the Plan Administrator.

D. Children up to age 26 whose primary residence is with the employee and who depend upon the employee for support and maintenance, for whom the employee or employee's spouse has been named legal guardian. The company will require proof of legal responsibility in order for them to become an eligible family member.

E. Disabled children age 26 and over if all of the following apply:

1) is a child as defined in point B above.
2) is unmarried.
3) became handicapped prior to reaching age 26.
4) is dependent upon the Employee/Employee's spouse for support and maintenance.
5) is incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders.

To qualify for this disabled child coverage extension, the plan administrator must receive proof of the requirements above. After this initial proof, the plan administrator may request proof again two (2) years later, and each year thereafter.

Those situations specifically excluded from the definition of a Dependent are:

1. Any person who is not a resident of the United States of America.
2. A spouse who is legally separated or divorced from the Employee.
3. Any spouse on active military duty.
4. Any Dependent covered under this Plan as an individual Employee.
5. Any person who is covered as a Dependent by another Employee of the Company.

Dependent Coverage

Eligibility under the terms of the Plan for benefits payable or Eligible Expenses of a Dependent.

Durable Medical Equipment

Equipment prescribed by the attending Physician which meets all of the following requirements: 1) it is Medically Necessary; 2) it can withstand repeated use; 3) it is not disposable; 4) it is not useful in the absence of an Illness or Injury; 5) it would have been covered if provided in a Hospital; and 6) it is appropriate for use in the home.

Eligible Expense

Any Medically Necessary treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

Eligible Provider

Eligible Providers shall include the following legally licensed or duly certified health care providers to the extent that same, within the scope of their license, are permitted to perform services which are considered Eligible Expenses under the Plan:

- Chemical Dependency Treatment Center
- Ambulatory Surgical Center
- Audiologist (MS)
- Birthing Center
- Certified Counselor
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinic
- Dentist
- Dialysis Center
- Home Health Agency
- Hospice
- Hospital
- Laboratory
- Licensed Practical Nurse
- Medical Supply Purveyor
- Midwife
- Nurse Practitioner
- Occupational Therapist
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopath
- Outpatient Psychiatric Treatment Facility
- Outpatient Substance Abuse Treatment Facility
- Pharmacy/Pharmacist
- Physical Therapist
- Physician (M.D.)
- Physician's Assistant
- Podiatrist
- Professional ambulance service
- Psychiatrist
- Psychologist
- Registered Dietitian
- Registered Nurse
- Respiratory Therapist
- Skilled Nursing Facility
- Social Worker
- Speech Therapist

"Eligible Provider" shall not include the Covered Individual or any close relative of the Covered Individual.

Emergency

An "Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Employee

An active Employee of the Company receiving compensation from the Company for services rendered to the Company. Employee means a person who is in an Employer-Employee relationship with the Company and who is classified by the Company as a regular Employee. The term "Employee" shall not include any individual classified by the Company as an independent contractor, a consultant, an individual performing services for the Company who has entered into an independent contractor or consultant agreement with the Company (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common-law employee) or a leased employee as defined in Section 414(n) of the Code. The term Employee does not include any employee covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that health care benefits were the subject of good faith bargaining between the employee's bargaining representative and the Company. The term Employee does not include an employee classified by the Company as a temporary employee.

Employee Coverage

Eligibility under the terms of the Plan for benefits payable for Eligible Expenses of an Employee.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Expenses Incurred

The day supplies or services are rendered.

Experimental

Any medical procedure, equipment, treatment, or course of treatment, or drug or medicine that is limited to research, not proven in an objective manner to have therapeutic value or benefit, restricted to use at medical facilities capable of carrying out scientific studies, or is of questionable medical effectiveness. To determine whether a procedure is experimental the Company will consider, among other things, commissioned studies, opinions, and references to or by the American Medical Association, the Federal Drug Administration, the Department of Health and Human Services, the National Institute of Health, the Council of Medical Specialty Societies and any other association or federal program or agency that has the authority to approve medical testing or treatment.

Family

A Covered Employee and his eligible Dependents.

Full-Time Work

A basis whereby an Employee works for the Company for an average of at least 30 hours per week on a regular basis. Such work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Employee to travel and for which he receives regular earnings from the Company.

Home Health Care Agency

A Medicare-approved public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must be primarily engaged in and duly licensed by the appropriate licensing authority (if such licensing is required) to provide skilled nursing services and other therapeutic services. It must have policies established by a professional group associated with the agency or organization including at least one Physician and at least one Registered Nurse (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a Physician or Registered Nurse. Its staff must maintain a complete medical record on each individual and it must have a full-time administrator.

Home Health Care Plan

A program for continued care and treatment of the Covered Individual, established and approved in writing by the Covered Individual's attending Physician. The attending Physician must certify that the proper treatment of the Illness or Injury would require continued Confinement as a resident inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice

A health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Individuals suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and its staff must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice and Palliative Care Organization (NHPCO) and applicable state licensing.

Hospital

An institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to an ill or injured person on an inpatient basis at the patient's expense.
2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to hospitals.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury.
4. Such treatment is provided for compensation by or under the supervision of Physicians, with continuous 24 hour nursing services by Registered Nurses (R.N.'s).
5. It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

The definition of "Hospital" will also include an institution specializing in the care and treatment of mental health disorders, chemical dependency (alcoholism and drug abuse), provided such facility is duly licensed if, licensing is required by law, where it is located.

Hospital Miscellaneous Expenses

The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Individual which are Medically Necessary for the treatment of such Covered Individual. Hospital miscellaneous expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness

A bodily disorder, disease, physical Sickness, mental infirmity, or functional nervous disorder of a Covered Individual. Illness shall include pregnancy and any complications of pregnancy.

Injury

The term "Injury" shall mean only accidental bodily Injury caused by an external force. All injuries to one person from one accident shall be considered an "Injury."

In-Network Benefit

The benefit percentage paid if a Covered Individual utilizes the services of a Network Provider.

Inpatient Care

Hospital Room and Board and general nursing care for a person confined in a Hospital or Skilled Nursing Facility/Extended Care Facility as a bed patient. Observation care that extends beyond twenty-three (23) hours will be considered inpatient and allowed at the rate of inpatient care.

Intensive Care Unit (ICU)

An area within a Hospital which is reserved, equipped, and staffed by the Hospital for the treatment and care of critically ill patients who require extraordinary, continuous, and intensive nursing care for the preservation of life.

Licensed Practical Nurse (L.P.N.)

An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Lifetime

The term "lifetime," which is used in connection with benefit maximums and limitations, means the period during which the person is covered under the Company Health Plan, whether or not coverage is continuous. Under no circumstances does "lifetime" mean during the lifetime of the Covered Individual.

Medically Necessary

The service a patient receives which is recommended by a Physician and is required to treat the symptoms of a certain Illness or Injury. Although the service may be prescribed by a Physician, it does not mean the service is Medically Necessary. The care or treatment 1) must be consistent with the diagnosis and prescribed course of treatment for the Covered Individual's condition; 2) must be required for reasons other than the convenience of the Covered Individual or the attending Physician; 3) is generally accepted as an appropriate form of care for the condition being treated; and 4) is likely to result in physical improvement of the patient's condition which is unlikely to ever occur if the treatment is not administered.

Medicare

The medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

Named Fiduciary

Eastern Shoshone Tribe, which has the authority to control and manage the operation and administration of the Plan.

Newborn

An infant from the date of birth until the mother is discharged from the Hospital.

Occupational Therapist

A licensed practitioner who treats, primarily, the loss of motor function of skeletal muscles by educating the patient to use other muscles and/or artificial devices to enable them to perform acceptably in any particular occupation or the ordinary tasks of daily living.

Out-of-Network Benefit

The benefit percentage paid if a Covered Individual receives services from a provider who is not contracted with the Preferred Provider Organization.

Outpatient

The classification of a Covered Individual when that Covered Individual received medical care, treatment, services, or supplies at a clinic, a Physician's office, a Hospital if not a registered bed patient at that Hospital, an Outpatient Psychiatric Treatment Facility, or an Outpatient Substance Abuse Treatment Facility.

Outpatient Psychiatric Treatment Facility

An administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Outpatient Substance Abuse Treatment Facility

An institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or substance abuse; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services that may be required; is at all times supervised by a staff of Physicians; prepares and maintains a written plan of treatment for each patient, based on the patient's medical, psychological, and social needs and supervised by a Physician; and meets licensing standards.

Outpatient Surgery

Outpatient surgery includes, *but is not limited to*, the following types of procedures performed in a hospital or surgi-center:

1. Operative or cutting procedures for the treatment of an illness or injury;
2. The treatment of fractures and dislocations; or
3. Endoscopic or diagnostic procedures such as biopsies, cystoscopy, bronchoscopy, and angiocardiography.

Physical Therapist

A licensed practitioner who treats patients by means of electro-, hydro-, aero-, and mechano-therapy, massage and therapeutic exercises. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.

Physician

A legally licensed medical or dental doctor or surgeon, osteopath, podiatrist, optometrist, chiropractor or registered clinical psychologist to the extent that same, within the scope of his license, is permitted to perform services provided in this Plan. A Physician shall not include the Covered Individual or any Close Relative of the Covered Individual.

Plan

The term "Plan" means without qualification the Plan outlined herein.

Plan Administrator

The Company, which is responsible for the management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

Plan Sponsor

Eastern Shoshone Tribe

Pre-Authorization

Pre-Authorization determines whether a proposed treatment is covered by the Health Plan. An Eligible Provider or a Covered Individual may submit information to the Claims Administrator regarding a proposed service to determine if and at what level the service is covered by the Plan.

Pre-Existing Condition

A condition of a Covered Individual, whether physical or mental, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the three (3) month period immediately preceding his employment date or effective date of coverage, whichever is applicable. Medical care, services, or supplies shall include, but shall not be limited to, medication, therapy, x-ray or lab tests, counseling, or any other treatment recommended by a licensed provider of medical care or services.

Preferred Provider Organization (PPO)

An Organization that has contracted with the Plan Sponsor to provide services to Covered Individuals at specific rates.

Pregnancy

That physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

Prescription

All drugs that are required under Federal law to bear the label, "Caution: Federal law prohibits dispensing without prescription," or any substitute required label, and injectable insulin (whether or not by prescription), as long as the drug was prescribed by a licensed Physician.

Primary Plan

A plan whose allowable benefits are not reduced by those of another plan.

Pronouns

Any references to "You, Yours, or Yourself" means the eligible Employee and Covered Dependents. "He, His, Him" refers to either sex; not to be discriminatory, but to avoid "he/she" type wording.

Psychiatric Care

The term "psychiatric care," also known as psychoanalytic care, means treatment for a mental Illness or disorder, a functional nervous disorder, alcoholism, or drug addiction. A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic depression.

Psychologist

A registered clinical psychologist. A provider who has a doctorate degree in psychology with two (2) years clinical experience and who meets the standards of a national register.

Qualified Medical Child Support Order (QMCSO)

In order to meet the definition of a Qualified Medical Child Support Order (QMCSO), a court order or divorce decree must contain all of the following information:

1. The Employee's name and last known address.
2. The Dependent's full name and address.
3. A reasonable description of the coverage to be provided or the manner in which coverage will be established, i.e. through the employer.
4. The period for which coverage must be provided.

A National Medical Support notice, issued pursuant to ERISA section 609(a)(5)(C) and applicable regulations, will also meet the definition of a QMCSO.

Registered Nurse (R.N.)

An individual who has received specialized nursing training and is authorized to use the designation of "R.N.," and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Review Organization

The organization contracting with the Company to perform cost containment services.

Room and Board

All charges, by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility/Extended Care Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care (by whatever name called).

Semi-Private

A class of accommodations in a Hospital or Skilled Nursing Facility/Extended Care Facility in which at least two patient beds are available per room.

Skilled Nursing Facility or Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law, and one which meets all of the following conditions:

1. It is licensed to provide and is engaged in providing, on an inpatient basis for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. Its staff maintains a complete medical record on each patient.
5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of mental disorders.
7. It is approved and licensed by Medicare

This term shall apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, Extended Care Facility, or any such other similar facility.

Social Worker

An individual who is qualified through education, training, and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions, or substance abuse.

Speech Therapist

An individual who is skilled in the treatment of communication and swallowing disorders due to Illness, Injury or birth defect, who is a member of the American Speech and Hearing Association and has a Certificate of Clinical Competence and who is licensed in the state in which services are provided.

Surgical Procedures

Cutting, suturing, treatment of burns, correction of fractures, reduction of dislocation, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, or injection of sclerosing solution by a licensed Physician.

TEFRA

The Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Therapy Services

Services or supplies used for the treatment of an Illness or Injury to promote the recovery of a Covered Individual. Therapy services are covered to the extent specified in the Plan and may include:

1. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
2. Dialysis Treatments - the treatment of acute or chronic kidney disease which may include the supportive use of an artificial kidney machine.
3. Occupational Therapy - treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
4. Physical Therapy - the treatment by physical means, electrotherapy, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of body part.
5. Radiation Therapy - the treatment of disease by X-ray, radium, or radioactive isotopes.
6. Respiration Therapy - introduction of dry or moist gases into the lungs for treatment purposes.
7. Speech Therapy - treatment of communication and swallowing disorders due to an Illness, Injury or birth defect.

TMJ

"TMJ" means temporomandibular joint syndrome and all related complications or conditions.

Total Disability (Totally Disabled)

A physical state of a Covered Individual resulting from an Illness or Injury which wholly prevents:

1. An Employee from engaging in his regular or customary occupation and from performing any and all work for compensation or profit.
2. A Dependent from performing the normal activities of a person of like age and sex and in good health.

Usual, Customary and Reasonable (UCR)

The term "usual, customary, and reasonable" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a geographic area or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise.

Well-Care

The term "well-care" means medical treatment, services, or supplies rendered solely for the purpose of health maintenance and *not* for the treatment of an Illness or Injury.

EXHIBIT 2

unum
Better benefits at work.

EASTERN SHOSHONE TRIBE

Who depends on you?

ENROLLMENT BEGINS MONDAY, 8/18/2014, AND ENDS FRIDAY, 8/22/2014

CE-63182 (08-14)

EXHIBIT
tabbies
2

What your benefits can do for you

Benefits are a valuable part of your compensation package. They can help protect important things like your income and your assets if you become sick or injured and can't work. Some insurance products can help pay for expenses that aren't covered by your health insurance like copays, deductibles and other out-of-pocket expenses. Other plans can help your family deal with financial realities if you should die prematurely.

That's why Eastern Shoshone Tribe has made these valuable insurance products from Unum available for you and your family. The voluntary benefits described in this booklet can build on the benefits already provided by Eastern Shoshone Tribe, giving you additional protection that you and your family may need. Keep in mind that you get more competitive rates when you buy through the workplace. We encourage you to take a look at the information in this booklet so you can make informed choices about these benefits.

What should I do next?

- Review the following benefit information.
- To enroll, see your supervisor to schedule a one-on-one meeting with a benefit representative.*

Your enrollment begins 8/18/2014 and ends 8/22/2014.

Eastern Shoshone Tribe is pleased to make these benefits available and encourages you to learn more.

**Benefit representatives are not paid based on whether or not they sell you an insurance policy. Instead, they are there to help answer questions on what products might best suit your insurance needs. They can also explain pricing and help you complete the application process.*

Your benefit overview

BENEFITS	FUNDING	COVERAGE OPTIONS
Medical benefits administered by WebTPA	Shared funding	• Can provide benefits for office visits, emergency medical care, hospital services and prescription drugs.
Dental benefits administered by WebTPA	Shared funding	• Can provide benefits for cleaning, x-rays, fillings, root canal, crowns and bridges.
Vision benefits administered by WebTPA	Shared funding	• Can provide benefits for a yearly eye exam, lenses, frames and/or contacts.
NEW Group Term Life/Accidental Death and Dismemberment (AD&D) Insurance through Unum	Employer paid	• Council Members: Can provide a Term Life and AD&D flat benefit amount of $50,000. • All other employees: Can provide a Term Life and AD&D benefit amount of two times annual earnings to a max of $50,000.
NEW Group Short Term Disability Insurance through Unum	Employer paid	• Benefit can pay 60% of your pre-disability earnings to a maximum of $400 per week. • Benefits begin to accrue after 14 days due to a covered injury and 14 days due to a covered illness; benefit period is up to 12 weeks. • Short-Term Disability Insurance is offered to all full time employees who participate in the employer sponsored medical plan.
NEW Group Voluntary Term Life/ Accidental Death and Dismemberment (AD&D) Insurance through Unum	Employee paid	• Enroll for up to $150,000 for yourself and $25,000 for your spouse, guaranteed issue. • Apply for up to five times your annual salary to a maximum of $500,000; coverage available for spouse and children.
NEW Whole Life Insurance through Unum	Employee paid	• Policy can build cash value. • Premiums do not increase as you get older. • Also available for spouse and children.
NEW Group Accident Insurance through Unum	Employee paid	• Voluntary coverage can pay a specific dollar amount for both on-the-job and off-the-job accidents. • Family coverage also available.

Your medical insurance

Summary of medical benefits

[redacted]		
Calendar year deductible		
Individual	$1,000 deductible	$1,000 deductible
Family	$2,000 deductible	$2,000 deductible
Coinsurance	20%	30%
Out-of-pocket calendar year maximum		
Individual	$1,000	$1,000
Family	$2,000	$2,000
[redacted]		
Office visits		
Primary care physician	20% co-insurance	30% co-insurance
Specialist	20% co-insurance	30% co-insurance
Preventative care	0% co-insurance	0% co-insurance
Emergency medical care		
Emergency room	$50 co-pay/20% co-insurance/visit	$50 co-pay/30% co-insurance/visit
Urgent care	20% co-insurance	30% co-insurance
Ambulance	20% co-insurance	30% co-insurance
Prescription plan	Generic drugs: $10 co-pay/prescription (retail); $20 co-pay/prescription (mail order) Preferred brand drugs: $25 co-pay/prescription (retail); $50 co-pay/prescription (mail order) Non-preferred brand drugs: $50 co-pay/prescription (retail); $100 co-pay/prescription (mail order)	Generic drugs: $10 co-pay/prescription (retail); $20 co-pay/prescription (mail order) Preferred brand drugs: $25 co-pay/prescription (retail); $50 co-pay/prescription (mail order) Non-preferred brand drugs: $50 co-pay/prescription (retail); $100 co-pay/prescription (mail order)

This is a brief description of your benefits. Please refer to the Summary of Benefit and Coverage provided by your employer for full details of your benefits.

Your dental insurance

Smile! You have dental insurance.

Coverage is available from WebTPA.

Summary of dental benefits	
Benefit	
Deductibles and maximums	
Annual maximum	
Individual	$1,200
Covered services	
Preventive care (cleanings, X-rays, fluoride treatments)	100%
Basic services (lab tests, fillings, root canal, denture repair, periodontics, extractions)	80%
Major services (bridges, dentures, crowns, inlays, posts, implants)	60%
Orthodontics	
Individual	50%
Family	50% limited to unmarried dependent children up to age 20.
Lifetime maximum	$1,500 per covered individual; limited to unmarried dependent children up to age 20.

This is a brief description of your benefits. Please refer to the Summary of Benefit and Coverage provided by your employer for full details of your benefits.

Our smiles are important.

Your vision insurance

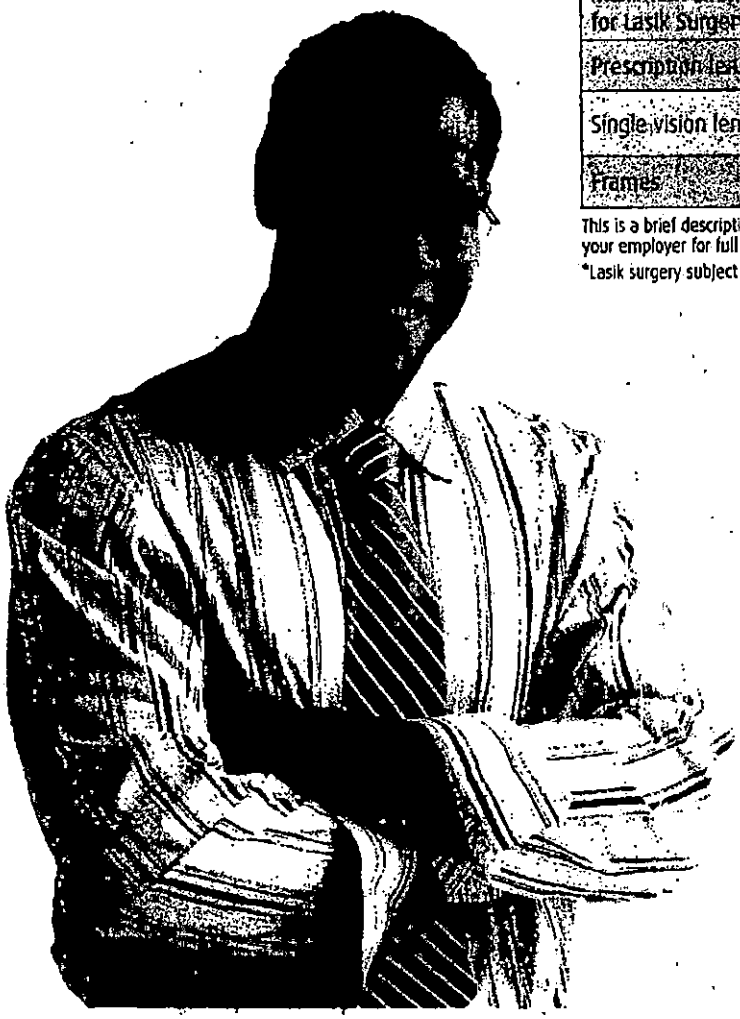
Where will your eyes take you today?

Whether it's a day in the life or a day to remember, you're covered. Coverage is available from WebTPA, and with them, you'll get the personalized eye care you deserve. WebTPA will help you see well, stay healthy, and get the most out of life.

Summary of vision benefits	
Eye examination	[illegible]
Maximum Annual Benefit	[illegible]
Maximum Lifetime Benefit for Lasik Surgery*	$500 per covered individual per lifetime
Prescription lenses	
Single vision lenses	One set of lenses or contact lenses per covered individual per calendar year
Frames	[illegible]

This is a brief description of your benefits. Please refer to the Summary of Benefit and Coverage provided by your employer for full details of your benefits.

*Lasik surgery subject to the limit listed above.



Helpful information

DID YOU KNOW?

Kick the habit

One of the best things you can do to stay healthy is to avoid tobacco products. Smoking is related to many serious health problems - including cancer. Need to quit? Talk to your doctor. There's lots of help available.[1]

Drink up

Your body is approximately 60% water, so it's important to stay hydrated. Most experts suggest drinking eight 8-oz. glasses of water a day.[2]

Feeling sleepy?

Some people can get by with only four or five hours of sleep a night, but most adults need a good seven or eight hours to feel rested. If you have trouble sleeping, talk to your doctor.[3]

How sweet it is

Did you know that you can lose up to four pounds a year by avoiding impulse candy purchases at the grocery store checkout? Cutting back on sugar is a great way to trim your waistline.[4]

Shoo the flu

The best way to beat the flu is to prevent it. Health experts recommend a yearly flu shot. Also wash your hands frequently. The U.S. Centers for Disease Control and Prevention lists hand-washing as one of the top ways to avoid catching the flu.[5]

Useful website resources

Healthfinder.gov

Healthfinder.gov has resources on a wide range of health topics selected from over 1,600 government and non-profit organizations to bring you the best, most reliable health information on the Internet.

USA.gov

An easy-to-search website designed to give you a centralized place to find information from U.S. local, state and federal government agency websites.

Nutrition.gov

Provides easy, online access to government information on food and human nutrition for consumers.

Womenshealth.gov

Offers free women's health information on more than 800 topics.

MedlinePlus.gov

Brings together authoritative information from the National Library of Medicine, the National Institutes of Health (NIH) and other government agencies and health-related organizations.

1 Source: iVillage: Your Total Health, "Smoking-tobacco," cited April 2009.
2 Source: iVillage: Your Total Health, "Water Basics," cited April 2009.
3 Source: iVillage: Your Total Health, "Insomnia," cited April 2009.
4 Source: iVillage: Your Total Health, "Diet-fitness," cited April 2009.
5 Source: iVillage: Your Total Health, "Healthline" and "Protect Yourself, Wash Those Germs Away," cited April 2009.

Unum is not affiliated with nor does it endorse the Internet sites listed in this document and therefore is not responsible for the accuracy of the information.

Group Voluntary Term Life Insurance

employee-paid

Why consider Group Voluntary Term Life?

Group Voluntary Term Life provides term life insurance at affordable group rates. And you get to choose the amount of coverage that's right for you.

Who is eligible?

If you are a Council member and work 30 hours per week, you have $50,000 of basic term life insurance paid for by Eastern Shoshone Tribe. If you are an active employee and work 30 hours per week, you have a term life insurance benefit amount of two times your annual earnings to a maximum of $50,000. It's a good foundation, but you may need more coverage to help meet your specific needs. Group Voluntary Term Life provides additional term life insurance at affordable group rates. And you get to choose the amount of coverage that's right for you.

How much coverage can I get?

Employee — Up to $150,000, guaranteed issue amount *(see next page)*.
Spouse — Up to $25,000, guaranteed issue amount.
Children — Up to 100% of your coverage, in increments of $2,000, to a maximum of $10,000.

Once you are enrolled in the plan, you and your spouse may purchase additional life coverage up to the guaranteed issue amounts without evidence of insurability.

Can I apply for more coverage?

Employee — Up to five times your annual salary in increments of $10,000, to a maximum of $500,000. Amounts over the guaranteed issue limit will require evidence of insurability *(see next page)*.

Spouse — Up to 100% of your coverage in increments of $5,000, to a maximum of $500,000. Amounts over the guaranteed issue limit will require evidence of insurability.

Your plan also includes Accidental Death and Dismemberment (AD&D) coverage equal to your life insurance coverage. In order to purchase life and AD&D insurance for your spouse and eligible children, you must buy coverage for yourself. They cannot have more coverage than you.

Coverage amounts for life and AD&D insurance for you and your spouse will reduce to 65% on your plan anniversary date the year you reach age 70, and will reduce to 50% on your plan anniversary date the year you reach age 75. Coverage may not be increased after a reduction.

Features you'll appreciate:

Portability/conversion — If you retire, reduce your hours or leave Eastern Shoshone Tribe, you can continue coverage for yourself, your spouse and your dependent children at the group rate. Portability is not available for those who have a medical condition which could shorten their life expectancy. In that case, you may be able to convert the term life policy to an individual life insurance policy.

Included with your AD&D plan

Education benefit — If you die within 365 days of a covered accident, this benefit can help defray the cost of tuition for your children if they are in college or other post-secondary school training.

Seat belt and airbag benefit — Pays an additional 10% benefit up to $25,000 if you die in a covered private passenger car accident while wearing a seat belt. An extra 5% benefit is paid if the seat is protected by an airbag and seat belt *and* your seat belt is properly fastened. The total combined maximum seat belt/airbag benefit is $30,000.

Repatriation benefit — If you or a covered dependent dies in an accident 100 or more miles from home, this benefit will help defray the costs of preparing and transporting the body to a chosen mortuary.

*An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment of age 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Life Planning Financial & Legal Resources is provided by Ceridian Corporation. This service is available with select Unum insurance offerings. Exclusions, limitations and prior notice requirements may apply, and service features, terms and eligibility criteria are subject to change. Ceridian Corporation is not engaged in rendering legal advice. Users should consult with their own attorneys. The services are not valid after termination of coverage and may be withdrawn at any time. Please contact your Unum representative for full details.

NOTE: To apply, attend a one-on-one meeting.

Insurance terms explained

Guarantee issue — If you enroll between 8/18/2014 and 8/22/2014 you can apply for up to $150,000 of Term Life Insurance for yourself and up to $25,000 for your spouse without answering any health questions or taking a physical exam. *That's what is meant by guaranteed issue.*

Evidence of insurability — If you elect coverage amounts above the guaranteed issue for yourself or your spouse, you will need to fill out and sign a medical history form. You may also be asked to take a health exam. *That's what is meant by providing evidence of insurability.*

Active employment — You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by Eastern Shoshone Tribe for working at least 30 hours each week, and you are performing the material and substantial duties of your regular occupation.

Voluntary Term Life coverage rates

Age	Employee rate per $10,000	Spouse rate per $5,000
<24	$.839	$.443
25–29	$.932	$.489
30–34	$1.254	$.650
35–39	$1.852	$.932
40–44	$2.818	$1.403
45–49	$4.393	$2.185
50–54	$6.474	$3.243
55–59	$9.269	$4.790
60–64	$11.925	$6.635
65–69	$16.993	$9.453
70–74	$32.097	$17.877
75+	$59.230	$35.263

Child life monthly rate is $0.858 per $2,000. One life premium covers all children.

AD&D coverage rates — Monthly

Employee	per $10,000	$1.01
Spouse	per $5,000	$.53
Child	per $2,000	$.011

Cost calculation

To calculate your cost, select coverage amount and rate based on your insurance age. To calculate your insurance age, subtract your year of birth from the year your coverage becomes effective.

For example: Let's say you are 38 and a non-tobacco user who would like to apply for $50,000 of voluntary Term Life Insurance. Take $50,000 and divide it by $10,000. Multiply that number by $1.852 (your rate based on your insurance age) and you get a monthly cost of $9.26.

Coverage amount	Increment	Rate	Weekly cost
Employee $_____	÷$10,000	x $_____	=$_____
Spouse $_____	÷$5,000	x $_____	=$_____
Children $_____	÷$2,000	x $_____	=$_____
		TOTAL WEEKLY COST =	$_____

Coverage amount	Increment	Rate	Weekly cost
Employee $_____	÷$10,000	x $_____	= $_____
Spouse $_____	÷$5,000	x $_____	= $_____
Children $_____	÷$2,000	x $_____	= $_____
		TOTAL WEEKLY COST =	$_____

We've got the basics covered!

Council Members: If you are an active employee who works 30 hours a week or more, you have Term Life Insurance at a flat benefit amount of $50,000 paid for by Eastern Shoshone Tribe.

All other employees: If you are an active employee who works 30 hours a week or more, you have Term Life Insurance at a benefit amount of two times your annual earnings to a maximum of $50,000 paid for by Eastern Shoshone Tribe.

In addition, you have an equal amount of Accidental Death and Dismemberment (AD&D) Insurance.

What features are included?

Accelerated benefit — If you become terminally ill and are not expected to live more than 12 months,.you may request up to 100% of your life insurance amount to the plan maximum without fees or present value adjustments. A doctor must certify your condition. Upon your death, any remaining benefit will be paid to your designated beneficiaries.

Portability/conversion — If you retire, reduce your hours or leave Eastern Shoshone Tribe, you can take this coverage with you, unless you have a medical condition which could shorten your life expectancy. In that case, you may be able to convert your term life policy to an individual life insurance policy.

Life Planning Financial & Legal Resources — Financial and legal support and counseling is available for beneficiaries and for covered employees and their spouses who are terminally ill.

Waiver of premium — If you become disabled (as defined by your plan) and are no longer able to work, your life premium payments will be waived during the period of disability.

Included with your AD&D plan

Education benefit — If you die within 365 days of a covered accident, this benefit can help defray the cost of tuition for your children if they are in college or other post-secondary school training.

Seat belt and airbag benefit — Pays an additional 10% benefit up to $25,000 if you die in a covered private passenger car accident while wearing a seat belt. An extra 5% benefit is paid if the seat is protected by an airbag and seat belt ***and*** your seat belt is properly fastened. The total combined maximum seat belt/airbag benefit is $30,000.

Repatriation benefit — if you or a covered dependent dies in an accident 100 or more miles from home, this benefit will help defray the costs of preparing and transporting the body to a chosen mortuary.

It's good to know my family is protected.

Coverage amounts for life and AD&D insurance will reduce to 65% of the original amount when you reach age 65, and will reduce to 50% when you reach age 70. Coverage may not be increased after a reduction.

Life Planning Financial & Legal Resources is provided by Ceridian Corporation. This service is available with select Unum insurance offerings. Exclusions, limitations and prior notice requirements may apply, and service features, terms and eligibility criteria are subject to change. Ceridian Corporation is not engaged in rendering legal advice. Users should consult with their own attorneys. The services are not valid after termination of coverage and may be withdrawn at any time. Please contact your Unum representative for full details.

Group Short Term Disability Insurance

employer-paid

Why do you need Short Term Disability Insurance?

It's not life-threatening — a broken leg, a hysterectomy or maybe you're planning on having a baby — but you're going to miss work for several weeks, even a month or two. How are you going to pay the bills? Maybe you have a week or two of sick leave or earned time off, but after that, what happens?

Fortunately, Eastern Shoshone Tribe provides Group Short Term Disability Insurance for active employees working a minimum of 30 hours per week who participate in the Employer sponsored medical plan. It can pay you a percentage of your income if you become disabled due to a covered injury or illness.

What kind of coverage is available?

You are eligible to receive benefits after you have been unable to work for 14 days due to a covered injury or illness.

If you meet the definition of disability *(see information at the back of the booklet)*, you would be eligible to receive a weekly benefit of 0% of your weekly earnings to a maximum of $400 per week. You may receive a benefit for up to 12 weeks.

The amount of benefit you receive from the plan may be reduced or offset by income from other sources — such as amount you receive or are entitled to receive under a state compulsory benefit plan, automobile liability insurance, legal judgments and settlements, certain retirement plans, other group disability programs or insurance and amounts you (and your family, if applicable) receive or are entitled to receive from Social Security or similar governmental programs.

A feature you'll appreciate:

- **Rehabilitation and return-to-work assistance** — If you are deemed eligible and are participating in the program, Unum will pay an additional benefit of 10% of your gross disability payment to a maximum of $250 per week.

This benefit is important to me.

Group Accident Insurance

employee-paid

Hearing the word "oops" is never a good thing

Maybe your spouse fell off the ladder while cleaning the gutters, or your child tripped and broke a tooth playing outside, or you threw your back out cleaning the garage.

Unexpected accidents always have lousy timing, especially when you are responsible for insurance deductibles and out-of-pocket costs. You need a plan that helps you protect your family and your wallet. Unum's Accident Insurance gives you something to fall back on.

How does it work?

Accident Insurance can help provide financial protection if you suffer a covered injury and need treatment. It can pay a benefit directly to you to offset the high cost of co-pays, deductibles and other expenses your medical insurance doesn't cover. This plan also covers on-the-job accidents.

Unum's coverage provides a lump-sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Family coverage options

- Employee — If you are actively at work *(see information at the back of the booklet)*
- Spouse — Ages 17–64
- Child(ren) — Dependent children age newborn until their 26th birthday, regardless of marital or student status

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must reside in the U.S. to receive coverage.

Features you'll appreciate

- **Catastrophic Benefit** — This pays an additional sum if a covered individual has a serious injury — such as loss of sight, hearing or a limb.
- **A Wellness Benefit is also included** — Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including:
  - Blood tests
  - Chest X-rays
  - Stress tests
  - Colonoscopies
  - Mammograms

  If you have purchased coverage with multiple $50 wellness benefits, Unum will pay wellness benefits for two policies (maximum benefit: $100). This does not apply to policies with $75 or $100 wellness benefit amounts. A full list of covered tests will be provided in your certificate.

Why should I buy at work?

- No health questions to answer. If you apply, you automatically receive this base plan.
- This plan is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.
- Premiums are conveniently deducted from your paycheck.

Accident rates

Employee	$4.10
Employee and spouse	$6.76
Employee and child(ren)	$7.40
Employee, spouse and child(ren)	$10.06

For illustrative purposes only. Actual cost may vary.

Schedule of Benefits - Level 2

Covered injuries	Benefit amount
Fractures	
Open	Up to $7,500
Closed	Up to $3,750
Chips	25% of closed amount
Dislocations	
Open	Up to $6,000
Closed	Up to $3,000
Burns	
At least 10 square inches, but less than 20 square inches	2nd degree – $0 3rd degree – $2,500
At least 20 square inches, but less than 35 square inches	2nd degree – $0 3rd degree – $5,000
35 or more square inches of the body surface	2nd degree – $1,000 3rd degree– $10,000
Skin grafts for 2nd and 3rd degree burns	50% of burn benefit
Skin graft for any other accidental traumatic loss of skin	
At least 10 square inches, but less than 20 square inches	$150
At least 20 square inches, but less than 35 square inches	$250
35 or more square inches of the body surface	$500
Concussion	$150
Coma	$10,000
Ruptured disc	$800
Knee cartilage	
Torn	$750
Exploratory	$150
Laceration	$25 – $600
Tendon/ligament and rotator cuff	
Repair of one	$800
Repair of two or more	$1,200
Exploratory only	$150
Dental work, emergency	
Extraction	$100
Crown	$300
Eye injury	$300

† Catastrophic accidental benefit — payable after fulfilling a 365 day elimination period.

In CT, there is a $500 benefit payable for outpatient emergency room medical care for accidental ingestion of a controlled substance.

1 In CA and CT, no ground or air ambulance benefit is payable.
2 In KS, no chiropractic benefit is payable.
3 In NJ, no transportation benefit is payable.
4 In NJ, no lodging benefit is payable.
5 In ME, catastrophic benefits amounts vary. In PA, no catastrophic accidental dismemberment benefit is payable.
6 In PA, no paralysis benefit is payable.

Accident coverage is a limited policy.

Emergency and hospitalization benefits	Benefit amount
Ambulance[1] (ground, once per accident)	$400
Air ambulance	$1,500
Emergency room treatment	$150
Emergency treatment in physician office/urgent care facility	$75
Hospital admission (admission or intensive care admission once per covered accident)	$1,000
Intensive care admission (same as above)	$1,500
Hospital confinement (per day up to 365 days)	$200
Intensive care confinement (per day up to 15 days)	$400
Medical imaging test (once per accident)	$200
Outpatient surgery facility service (once per accident)	$300
Pain management (epidural, once per accident)	$100
Treatment and other services	**Benefit amount**
Surgery benefit	
Open abdominal, thoracic	$1,500
Exploratory (without repair)	$150
Hernia repair	$150
Physician follow-up visit (2 visits per accident)	$75
Chiropractic visit[2] (up to 3 visits per calendar year)	$25
Therapy services (up to 10 per accident)	
Occupational therapy	$25
Speech therapy	$25
Physical therapy	$25
Prosthetic device or artificial limb	
One	$750
More than one	$1,500
Appliance (once per accident)	$100
Blood, plasma and platelets	$400
Travel due to accident[3] Transportation of more than 50+ miles from residence; 3 trips per accident; max 1,200 miles per round trip[4]	$0.40 per mile
Lodging (per night up to 30 days per accident)	$150
Rehabilitation unit confinement (per day up to 15 days; max 30 days per calendar year)	$100

Accidental death and other covered losses	Benefit amount
Accidental death*	
Employee	$50,000
Spouse	$20,000
Child	$10,000
*The accidental death benefit triples if the insured individual is injured as a fare-paying passenger on a common carrier: Employee – $150,000; spouse – $60,000; child – $30,000	
Initial accidental dismemberment — one benefit per accident, not payable with initial accidental loss	
Loss of both hands or both feet; or	$15,000
Loss of one hand and one foot; or	$15,000
Loss of one hand or one foot;	$7,500
Loss of two or more fingers, toes or any combination; or	$1,500
Loss of one finger or toe	$750
Catastrophic accidental dismemberment† — once per lifetime, not payable with catastrophic loss‡ Loss of both hands or both feet; or loss of one hand and one foot	
Employee (prior to age 65)	$100,000
– Spouse and child	$50,000
Employee (ages 65–69)	$50,000
– Spouse and child	$25,000
Employee (70+ years old)	$25,000
– Spouse and child	$12,500
Accidental loss — paralysis, sight, hearing and speech[6] Initial accidental loss — one benefit per accident, not payable with initial dismemberment	
Permanent paralysis; or	$15,000
Loss of sight of both eyes; or	$15,000
Loss of sight of one eye; or	$7,500
Loss of the hearing of one ear	$7,500
Catastrophic accidental loss† — once per lifetime, not payable with catastrophic dismemberment Permanent paralysis; or loss of hearing in both ears; or loss of the ability to speak; or loss of sight of both eyes	
Employee (prior to age 65)	$100,000
– Spouse and child	$50,000
Employee (ages 65–69)	$50,000
– Spouse and child	$25,000
Employee (70+ years old)	$25,000
– Spouse and child	$12,500

Whole Life Insurance

employee-paid

Who relies on you?

You're special to a lot of people. If something happened to you, you couldn't be replaced. But life insurance lets you leave something for your loved ones. Whether they need the money to pay for basic living expenses, an education or just your final arrangements, it's valuable help at a difficult time. In addition, whole life insurance also offers additional benefits to you while you are living:

- The policy builds cash value at a guaranteed rate of 4.5%.* Once your cash value builds to a certain level, you can borrow from the cash value or use it to buy a reduced policy with no more premiums due.
- The amount you pay does not increase with age.
- You get affordable rates when you buy this policy through your employer, and it is paid for through convenient payroll deduction.
- The death benefit (also known as the policy's "face amount") remains constant and does not decrease as you get older. The death benefit can only be reduced if you have borrowed money from the value of the policy and still owe it.
- If you are actively at work *(see information at the back of the booklet)* for a minimum of 20 hours per week, you can sign up during Eastern Shoshone Tribe's enrollment period and apply for $35,000 of coverage without taking a medical exam. However, you may be asked several health questions.
- If you have basic term life coverage, whole life can offer the additional financial protection you may need.
- You own the policy and can take it with you if you leave the company or retire.

Who can get coverage?

You can purchase individual coverage for:

- Yourself — age 15 to 80
- Your spouse — age 15 to 80
- Your children, stepchildren, legally adopted children and grandchildren — age 14 days until their 26th birthday

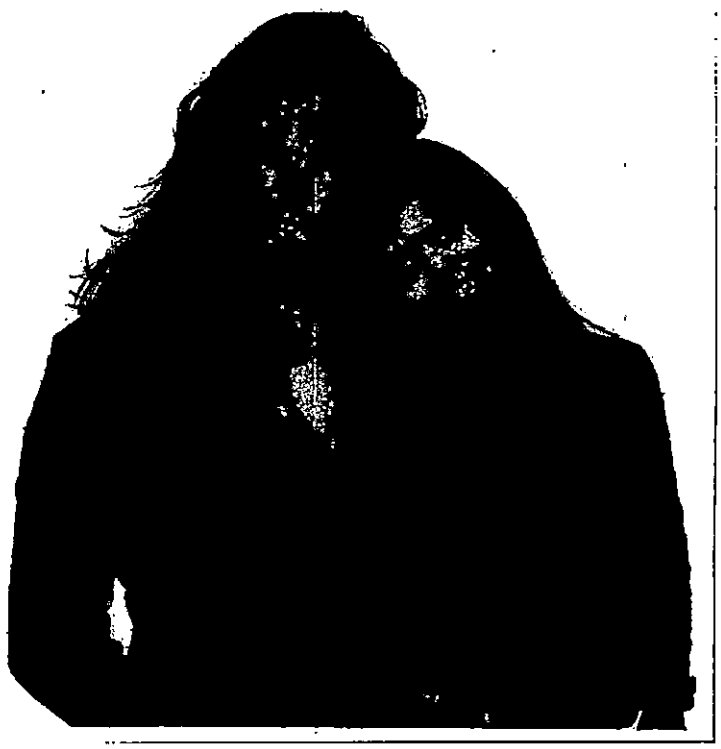
Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must reside in the U.S. to receive coverage.

[There may be two life coverage options available for your spouse. You may purchase an individual policy or a Spouse Term Life benefit.

- Individual spouse coverage — Can be purchased without purchasing employee coverage. The minimum policy amount and actual benefit amount is based on coverage amount chosen and age at issue. If you leave your employer, you can keep your spouse's policy and be billed directly at home.
- Spouse Term Life benefit — Employees must purchase coverage to add this Spouse Term Life benefit. Coverage is available from $5,000 to $25,000 and lasts for 20 years. This coverage amount cannot exceed the employee base coverage amount. This benefit is not available if you purchase individual coverage for your spouse and will be cancelled if employee coverage is cancelled.]

There may be two life coverage options available for your children. You may purchase an individual policy, a term life benefit or both.

- Individual child coverage — Can be purchased without purchasing employee or spouse coverage. Each policy covers one child or grandchild; you can purchase coverage for each of your children/grandchildren. Coverage is available up to $50,000 — benefit amounts are based on issue age and premium selected. Your children can keep coverage, even if you leave your employer.]
- Child Term Life benefit — Employees must purchase coverage to add the Child Term Life benefit. This benefit covers all eligible children. Coverage is available from $1,000 to $10,000 and ends when your policy ends or when the last child turns 25. At that time, children are guaranteed the right to buy an individual whole life policy at five times the amount of their rider. Coverage will be cancelled if employee coverage is cancelled.



Whole life insurance
employee-paid

Additional features

- Living Benefit Option Rider — Automatically included at no extra charge on all policies. You can request up to 100% of the death benefit amount (to a maximum of $150,000) if you are diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout you receive while you are living would reduce the amount of the benefit that would be paid to your beneficiaries when you die.

How much does it cost?

Sample rates

$10,000 benefit amount				
25	N/A	N/A	N/A	N/A
35	N/A	N/A	$4.25	$4,009
45	$4.32	$2,856	$7.32	$3,197
55	$8.25	$1,645	$13.75	$1,776
65	$17.00	$2,327	$24.20	$2,400
$50,000 benefit amount				
25	$8.38	$19,679	$14.60	$22,372
35	$12.88	$17,701	$21.22	$20,046
45	$21.59	$14,280	$36.58	$15,986
55	$41.22	$8,227	$68.75	$8,881
65	$84.97	$11,636	$120.98	$12,001
$100,000 benefit amount				
25	$16.75	$39,358	$29.20	$44,743
35	$25.75	$35,402	$42.43	$40,091
45	$43.18	$28,561	$73.16	$31,971
55	$82.43	$16,454	$137.50	$17,761
65	$169.93	$23,273	$241.97	$24,002

*The policy accumulates cash value based on a non-forfeiture interest rate of 4.5% and the 2001 CSO mortality table. The cash value is guaranteed and will be equal to the values shown in the policy.

**Or 10th year, whichever is later.

Sample rates do not include charges for additional features.

[redacted]

Notes

Limitations, exclusions, terminations

GROUP VOLUNTARY TERM LIFE INSURANCE

Guarantee issue

If you and your eligible dependents enroll during this enrollment period (8/18/2014 through 8/22/2014), you may apply for any amount of coverage up to $150,000 for yourself and any amount of coverage up to $25,000 for your spouse. Any coverage over the guaranteed issue amounts will be subject to evidence of insurability. If you and your eligible dependents do not enroll at this time, you can apply for coverage only during an annual enrollment period and will be required to furnish evidence of insurability for the entire amount of coverage.

If you and your eligible dependents enroll at this time and later wish to increase your coverage, you may increase your coverage, with evidence of insurability, at anytime during the year. However, you may wait until the next annual enrollment and only coverage over the guaranteed issue amounts will be subject to evidence of insurability.

Please contact your employer to confirm your eligibility date.

Effective date of coverage

To apply for coverage, complete your enrollment by 8/22/2014. If you apply for coverage after 8/22/2014, or if you choose coverage over the guaranteed issue amount, you will need to complete a medical questionnaire which you can get from your plan administrator. You may also be required to take certain medical tests at Unum's expense.

Your coverage will become effective on 10/1/2014. For employees who become eligible after this date please see your plan administrator for your effective date.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective.

Exception: Infants are insured from live birth.

Defining disability for dependents

Understanding how your policy defines "disability" is important.

Totally disabled means that, as result of an injury, sickness or a disorder:

Your dependent spouse:

- is confined in a hospital or similar institution;
- is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;
- is cognitively impaired;
- is receiving or is entitled to receive any disability income from any source due to any sickness or injury;
- is receiving chemotherapy, radiation therapy or dialysis treatment;
- is confined at home under the care of a physician for a sickness or injury; or
- has a life threatening condition.

Your dependent children:

- are confined in a hospital or similar institution;
- are receiving chemotherapy, radiation therapy or dialysis treatment; or
- are confined at home under the care of a physician for a sickness or injury.

Age reduction

Coverage amounts for life and AD&D insurance for you and your spouse will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Benefit payments for dependent coverage

Benefits on policies for a spouse and/or dependent children are paid to the employee. The maximum death benefit for a child between the ages of live birth and six months is $1,000.

New employees

Upon date of hire, all full time employees working a minimum of 30 hours per week must complete a 30 day orientation period. Upon completion of this 30 day orientation period, a 60 day waiting period will begin. Coverage will be effective 1st of the month following or coinciding with completion of the 60 day waiting period for all full time employees.

Changes to coverage

Each year you and your spouse will be given the opportunity to change your life coverage. You and your spouse may purchase additional life coverage up to the guaranteed issue amounts without evidence of insurability if you are already enrolled in the plan. Life coverage over the guaranteed issue amounts will be medically underwritten and will require evidence of insurability and approval by Unum's medical underwriters. The suicide exclusion will apply to any increase in coverage.

Limitations & exclusions

Life insurance benefits will not be paid for deaths caused by suicide in the first 24 months after your effective date of coverage. Additionally, no increased or additional benefits will be paid for deaths caused by suicide occurring within 24 months after the day such increased or additional insurance is effective.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Full benefit paid for loss of: life; both hands, or both feet, or sight of both eyes; one hand and one foot; one hand or one foot and the sight of one eye; speech and hearing.

Other losses may be covered as well. Please contact your plan administrator.

Limitations & exclusions

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
- suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane;
- war, declared or undeclared, or any act of war;
- active participation in a riot;
- committing or attempting to commit a crime under state or federal law;
- the voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of you or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol;
- intoxication — "being intoxicated" means you or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Termination of coverage for life and AD&D insurance

Your coverage and your dependents' coverage under the Summary of Benefits end on the earliest of:

- the date the policy or plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions;
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage.

In addition, coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of a divorce or annulment;
- for dependent coverage, the date of your death.

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

GROUP TERM LIFE INSURANCE

Delayed effective date of coverage

Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Age reduction

Coverage amounts for life and AD&D insurance for you and your spouse will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

New employees

Council members have a 0 day waiting period. All other employees have must complete a 30 day orientation. Upon completion of this 30 day orientation period, a 60 day waiting period will begin. Please contact your plan administrator to confirm your eligibility date.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Full benefit paid for loss of: life; both hands, or both feet, or sight of both eyes; one hand and one foot; one hand or one foot and the sight of one eye; speech and hearing.

Other losses may be covered as well. Please contact your plan administrator.

Limitations, exclusions, terminations

Limitations & exclusions

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
- suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane;
- war, declared or undeclared, or any act of war;
- active participation in a riot;
- committing or attempting to commit a crime under state or federal law;
- the voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of you or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol;
- intoxication — "being intoxicated" means you or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Termination of coverage for life and AD&D insurance

Your coverage and your dependents' coverage under the Summary of Benefits end on the earliest of:

- the date the policy or plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions;
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage.

In addition, coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of a divorce or annulment.
- for dependent coverage, the date of your death.

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

GROUP SHORT TERM DISABILITY INSURANCE

Definition of disability

You are disabled when Unum determines that due to sickness or injury:

- you are unable to perform the material and substantial duties of your regular occupation*; and
- you are not working in any occupation.

You must be under the regular care of a physician in order to be considered disabled.

*Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location, or in a specific region.

Effective date of coverage

Your effective date of coverage is 9/1/2014. For employees who become eligible after this date, see your plan administrator for your effective date.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

New employees

Upon date of hire, all full time employees working a minimum of 30 hours per week must complete a 30 day orientation period. Upon completion of this 30 day orientation period, a 60 day waiting period will begin.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include such items as disability income or other amounts you receive or are entitled to receive under state compulsory benefit laws; automobile liability; legal judgments and settlements; certain retirement plans; other group disability programs or insurance; and amounts you (and your family, if applicable) receive or are entitled to receive from Social Security or similar governmental programs.

Elimination period

The elimination period is the length of time of continuous disability that must be satisfied before you are eligible to receive benefits. If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days. If your disability is due to a sickness, your elimination period is 14 days.

Benefit duration

If you meet the definition of disability you may receive a benefit for up to 12 weeks.

Limitations/exclusions/terminations

Benefits would not be paid for loss resulting from:

- war, declared or undeclared, or any act of war;
- active participation in a riot;
- intentionally self-inflicted injuries;
- loss of a professional license, occupational license or certification;
- commission of a crime for which you have been convicted;
- any period of disability during which you are incarcerated;

Your coverage under the policy ends on the earliest of the following:

- the date the policy or plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions;
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

ACCIDENT INSURANCE

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- committing acts of terrorism;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, sailgliding, parasailing, parakiting;
- participating or attempting to participate in a felony, being engaged in an illegal occupation or being incarcerated in a penal institution;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. Unum also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.

In addition to the exclusions listed above, Unum will also not pay the catastrophic accidental dismemberment or catastrophic accidental loss benefit for the following injuries that are caused by or are the result of:

- an insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- injuries to a dependent child received during the birth.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer.

Otherwise, your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date you are no longer in an eligible group;
- date your eligible group is no longer covered;
- date of your death;
- last day of the period for which you made any required contributions; or
- last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of this policy.

Limitations, exclusions, terminations

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

WHOLE LIFE INSURANCE

Effective date of coverage

Your coverage will be effective on the first day of the month in which payroll deductions begin.

Limitations & exclusions

Life insurance benefits will not be paid for deaths caused by suicide. If within 24 months from the policy effective date, the insured commits suicide, whether sane or insane, Unum will not pay the death benefit. The amount payable by us in place of all other benefits, shall be the sum of premiums paid, without interest, less the sum of any debt and the cost of any riders.

Termination of coverage

The policy will terminate on the earliest of the following:

- written request by you to terminate the policy;
- the insured dies;
- the policy matures; or
- the loan value exceeds the guaranteed cash value of this policy.

Disclosures

ACTIVE EMPLOYMENT

Applies to Unum group insurance products

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by Eastern Shoshone Tribe for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

ACTIVELY AT WORK

Applies to Unum voluntary benefits

Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.

ADDITIONAL INFORMATION

Applies to all individually owned policies

This material is intended to be a brief description of the policy. The policy definitions, exclusions and limitations will be used to determine actual benefit decisions. After a policy is issued, you will have a 30-day period during which the policy can be cancelled at no cost to you. Product availability and provisions may vary by state.

QUESTIONS

If you have any questions about your coverage or how to enroll, please contact your employer.

unum
Better benefits at work.

Medical benefit is underwritten by:
Web TPA
Dallas, Texas

Dental benefit is underwritten by:
Web TPA
Dallas, Texas

Vision benefit is underwritten by:
Web TPA
Dallas, Texas

Group insurance products are underwritten by:
Unum Life Insurance Company of America
Portland, Maine

Whole life insurance is underwritten by:
Provident Life and Accident Insurance Company
Chattanooga, Tennessee

unum.com

The information in this booklet is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form(s) C.FP-1 et al, GA-1, L-21848, or contact your Unum representative. Unum complies with all state civil union and domestic partner laws when applicable.

CE-63182 (08-14)

FOR EMPLOYEES

EXHIBIT 3

FIRSTNATION HEALTH

First Nation Healthcare
10129 S YALE AVE SUITE 300
TULSA OK 74137-6097

20180322B02 J031 1361 15382

J031 [1,103] 4 of 4

Page 1 of 1

Forwarding Service Requested

CARLEY CLAUSEN
33 RANCH RD #15
RIVERTON WY 82501

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service

Questions? Please call
Customer Service at
(918) 518-6397

Participant Information

Group: Eastern Shoshone Tribe

Group No.: 101
Enrollee: Carley Clausen
Enrollee ID: 30
Paid Date: 03/27/2018

Claim#: 2018-068000293-0000
Patient: Carley Clausen

Patient#: 7300602
Provider: Sagewest Healthcare

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Ineligible Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
02/20-02/20/2018	80053	$200.66	$0.00	13 15	$56.18	$144.48	$0.00	$50.00	100%	$94.48
02/20-02/20/2018	J1940	$48.60	$0.00	13	$13.61	$34.99	$0.00	$0.00	100%	$34.99
02/20-02/20/2018	93005	$465.26	$0.00	13	$130.27	$334.99	$0.00	$0.00	100%	$334.99
02/20-02/20/2018	83735	$171.99	$0.00	13	$48.16	$123.83	$0.00	$0.00	100%	$123.83
02/20-02/20/2018	83880	$480.69	$0.00	13	$134.59	$346.10	$0.00	$0.00	100%	$346.10
02/20-02/20/2018	84484	$599.76	$0.00	13	$167.93	$431.83	$0.00	$0.00	100%	$431.83
02/20-02/20/2018	85025	$221.60	$0.00	13	$62.05	$159.55	$0.00	$0.00	100%	$159.55
02/20-02/20/2018	85610	$136.71	$0.00	13	$38.28	$98.43	$0.00	$0.00	100%	$98.43
02/20-02/20/2018	71045	$502.74	$0.00	13	$140.77	$361.97	$0.00	$0.00	100%	$361.97
02/20-02/20/2018	96374	$289.96	$0.00	13	$81.19	$208.77	$0.00	$0.00	100%	$208.77
02/20-02/20/2018	99284	$1,378.13	$0.00	13	$385.88	$992.25	$0.00	$0.00	100%	$992.25
Column Totals		$4,496.10	$0.00		$1,258.91	$3,237.19	$0.00	$0.00		$3,167.19
									Other Credits or Adjustments	$0.00
									Total Payment	$3,167.19

Patient's Responsibility: $50.00

Remark Code Description

13	PPO Benefits Applied
15	Co-Benefits Applied

Procedure Code Description

80053	Emergency Room Visit
J1940	Emergency Room Visit
93005	Emergency Room Visit
83735	Emergency Room Visit
83880	Emergency Room Visit
84484	Emergency Room Visit
85025	Emergency Room Visit
85610	Emergency Room Visit
71045	Emergency Room Visit
96374	Emergency Room Visit
99284	Emergency Room Visit

Important Information

Paid according to the First Health network agreement.

EXHIBIT
tabbies
3

FIRSTNATION HEALTH

First Nation Healthcare
10129 S YALE AVE SUITE 300
TULSA OK 74137-6097

Forwarding Service Requested

CARLEY CLAUSEN
33 RANCH RD #15
RIVERTON WY 82501

46

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service

Questions? Please call Customer Service at (918) 518-6397

Participant Information

Group: Eastern Shoshone Tribe

Group No.: 101
Enrollee: Carley Clausen
Enrollee ID: 30
Paid Date: 03/29/2018

Claim#: 2018-085000057-0000
Patient: Carley Clausen

Patient#: 2235050
Provider: Robert Novick

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
02/15-02/15/2018	92941	$6,445.00	$0.00	13	$5,521.90	$923.10	$0.00	$0.00	100%	$923.10
Column Totals		$6,445.00	$0.00		$5,521.90	$923.10	$0.00	$0.00		$923.10
									Other Credits or Adjustments	$0.00
									Total Payment	$923.10

Patient's Responsibility: $0.00

Claim Information

Paid according to the First Health network agreement.

Remark Code Description

13 PPO Benefits Applied

Procedure Code Description

92941 Cardiology

FIRSTNATION HEALTH

First Nation Healthcare
10129 S YALE AVE SUITE 300
TULSA OK 74137-6097

20180130802 J731 1361 16382

J731 [8,995] 9 of 15

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Forwarding Service Requested

CARLEY CLAUSEN
33 RANCH RD #15
RIVERTON WY 82501

44

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service

Questions? Please call
Customer Service at
(918) 518-6397

Participant Information

Group: Eastern Shoshone Tribe

Group No.: 101
Enrollee: Carley Clausen
Enrollee ID: 30
Paid Date: 04/27/2018

Claim#: 2018-113000136-0000
Patient: Carley Clausen

Patient#: 02940700226009
Provider: Angelo Santiago

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
11/07-11/07/2017	70546	$2,930.92	$0.00	13	$2,230.04	$700.88	$0.00	$0.00	100%	$700.88
11/07-11/07/2017	A9579	$200.00	$0.00	13	$146.40	$53.60	$0.00	$0.00	100%	$53.60
11/07-11/07/2017	36000	$10.00	$0.00		$0.00	$10.00	$0.00	$0.00	100%	$10.00
Column Totals		$3,140.92	$0.00		$2,376.44	$764.48	$0.00	$0.00		$764.48
									Other Credits or Adjustments	$0.00
									Total Payment	$764.48

Patient's Responsibility: $0.00

Claim Information

Paid according to the First Health network agreement.

Remark Code Description

13 PPO Benefits Applied

Procedure Code Description

70546 MRA
A9579 MRA
36000 Office Surgery

FIRSTNATION HEALTH

First Nation Healthcare
10129 S YALE AVE SUITE 300
TULSA OK 74137-6097

20180614B01 J1F9 1361 15382

J1F9 [44,414] 2 of 3

Page 1 of 1

Forwarding Service Requested

CARLEY CLAUSEN
33 RANCH RD #15
RIVERTON WY 82501

10b

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service

Questions? Please call Customer Service at (918) 518-6397

Participant Information

Group: Eastern Shoshone Tribe

Group No.: 101
Enrollee: Carley Clausen
Enrollee ID: 30
Paid Date: 06/13/2018

Claim#: 2018-162000047-0000
Patient: Carley Clausen

Patient#: 183968
Provider: Guardian Flight LLC- Lander

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
02/15-02/15/2018	A0427	$1,600.00	$0.00	13	$872.05	$727.95	$0.00	$0.00	100%	$727.95
02/15-02/15/2018	A0425	$584.50	$0.00	13	$327.92	$256.58	$0.00	$0.00	100%	$256.58
Column Totals		$2,184.50	$0.00		$1,199.97	$984.53	$0.00	$0.00		$984.53
									Other Credits or Adjustments	$0.00
Patient's Responsibility:		$0.00							Total Payment	$984.53

Claim Information

Paid according to the First Health network agreement.

Remark Code Description

13 PPO Benefits Applied

Procedure Code Description

A0427 Ambulance - Ground
A0425 Ambulance - Ground

Important Information

Paid according to the First Health network agreement.

FIRSTNATION HEALTH

First Nation Healthcare
10129 S YALE AVE SUITE 300
TULSA OK 74137-6097

20180615803 J1F9 1361 16382

J1F9 [44,414] 3 of 3

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Forwarding Service Requested

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

CARLEY CLAUSEN
33 RANCH RD #15
RIVERTON WY 82501

106

Customer Service

Questions? Please call Customer Service at (918) 518-6397

Participant Information

Group: Eastern Shoshone Tribe

Group No.: 101
Enrollee: Carley Clausen
Enrollee ID: 30
Paid Date: 06/13/2018

Claim#: 2018-162000048-0000
Patient: Carley Clausen

Patient#: 183986
Provider: Guardian Flight LLC- Lander

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
02/15-02/15/2018	A0429	$1,200.00	$0.00	13	$587.01	$612.99	$0.00	$0.00	100%	$612.99
02/15-02/15/2018	A0425	$1,078.00	$0.00	13	$680.61	$397.39	$0.00	$0.00	100%	$397.39
Column Totals		$2,278.00	$0.00		$1,267.62	$1,010.38	$0.00	$0.00		$1,010.38
									Other Credits or Adjustments	$0.00
									Total Payment	$1,010.38

Patient's Responsibility: $0.00

Claim Information

Paid according to the First Health network agreement.

Remark Code Description

13 PPO Benefits Applied

Procedure Code Description

A0429 Ambulance - Ground
A0425 Ambulance - Ground

Important Information

Paid according to the First Health network agreement.

FIRSTNATION HEALTH

First Nation Healthcare
10129 S YALE AVE SUITE 300
TULSA OK 74137-6097

20180912802
JCED
1361 16382

JCED [336] 1 of 1

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Forwarding Service Requested

**********MIXED AADC 826
PB-STL_UNSORTED-MACH-ENV 336 2
CARLEY CLAUSEN
33 RANCH RD #15
RIVERTON WY 82501

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service

Questions? Please call
Customer Service at
(918) 518-6397

Participant Information

Group: Eastern Shoshone Tribe

Group No.: 101
Enrollee: Carley Clausen
Enrollee ID: 30
Paid Date: 09/11/2018

Claim#: 2018-129000077-0000
Patient: Carley Clausen

Patient#: 78042P168969-P2
Provider: Caleb Wilson

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Ineligible Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
11/29-11/29/2017	31276	$3,591.00	$0.00	13	$1,059.35	$2,531.65	$0.00	$0.00	100%	$2,531.65
11/29-11/29/2017	30802	$486.00	$0.00	13	$559.36	-$73.36	$0.00	$0.00	0%	$0.00
11/29-11/29/2017	31276	$3,691.00	$0.00	13	$1,059.35	$2,631.65	$0.00	$0.00	100%	$2,531.65
11/29-11/29/2017	31255	$4,389.00	$0.00	13	$1,294.75	$3,094.25	$0.00	$0.00	100%	$3,094.25
11/29-11/29/2017	31255	$4,389.00	$0.00	13	$3,610.56	$778.44	$0.00	$0.00	100%	$778.44
11/29-11/29/2017	31267	$3,591.00	$0.00	13	$4,059.35	-$468.35	$0.00	$0.00	0%	$0.00
11/29-11/29/2017	31267	$3,591.00	$0.00	13	$3,059.35	$531.65	$0.00	$0.00	100%	$531.65
11/29-11/29/2017	30520	$3,592.00	$0.00	13	$3,059.64	$532.36	$0.00	$0.00	100%	$532.36
11/29-11/29/2017	31287	$2,098.00	$0.00	13	$2,618.91	-$520.91	$0.00	$0.00	0%	$0.00
11/29-11/29/2017	31287	$2,098.00	$0.00	13	$2,618.91	-$520.91	$0.00	$0.00	0%	$0.00
Column Totals		$31,416.00	$0.00		$22,999.53	$8,416.47	$0.00	$0.00		$10,000.00
									Other Credits or Adjustments	$0.00
Patient's Responsibility:		$0.00							Total Payment	$10,000.00

Remark Code Description

13 PPO Benefits Applied

Procedure Code Description

31276	Surgery
30802	Surgery
31276	Surgery
31255	Surgery
31255	Surgery
31267	Surgery
31267	Surgery
30520	Surgery
31287	Surgery
31287	Surgery

Important Information

Paid according to the First Health network agreement.

FIRSTNATION HEALTH

First Nation Healthcare
10129 S YALE AVE SUITE 300
TULSA OK 74137-6097

20190116B01 JBA8 1361 15182

JBA8 [2,827] 10 of 12

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Forwarding Service Requested

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

13

CARLEY CLAUSEN
33 RANCH RD #15
RIVERTON WY 82501

Customer Service

Questions? Please call
Customer Service at
(918) 518-6397

Participant Information

Group: Eastern Shoshone Tribe

Group No.: 101
Enrollee: Carley Clausen
Enrollee ID: 30
Paid Date: 11/29/2018

Claim#: 2018-199000022-0000
Patient: Carley Clausen

Patient#: 7305494
Provider: SageWest Health Care

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Ineligible Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
04/02-04/02/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/25-04/25/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/27-04/27/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/30-04/30/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/04-04/04/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/06-04/06/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/09-04/09/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/11-04/11/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/16-04/16/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/18-04/18/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/20-04/20/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
04/23-04/23/2018	93798	$315.32	$0.00	13	$88.29	$227.03	$0.00	$0.00	100%	$227.03
Column Totals		$3,783.84	$0.00		$1,059.48	$2,724.36	$0.00	$0.00		$2,724.36
									Other Credits or Adjustments	$0.00
									Total Payment	$2,724.36

Patient's Responsibility: $0.00

Remark Code Description

13 PPO Benefits Applied

Procedure Code Description

93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation
93798	Cardiac Rehabilitation

Important Information

Payment limited to Maximum Allowable Charge per terms of Plan Document; claim allowed at 150% of Medicare or Medicare equivalent rate. Consult Plan Document for details.

EXHIBIT 4

Aaron Vincent

From: Kailee Lynch <cjclausen896@gmail.com>
Sent: Wednesday, July 25, 2018 4:34 PM
To: aaron@johnvincentlaw.com
Subject: Fwd: Carley

---------- Forwarded message ----------
From: **Douglas Slack** <dlslack55@msn.com>
Date: Wed, Jul 25, 2018 at 1:30 PM
Subject: Fwd: Carley
To: "cjclausen896@gmail.com" <cjclausen896@gmail.com>

Sent from my iPhone

Begin forwarded message:

From: Ina Hurley <inah@esthealth.org>
Date: July 25, 2018 at 12:39:13 PM MDT
To: Douglas Slack <dlslack55@msn.com>
Subject: Carley

Carley,

I have been informed from Tami that you contacted her yesterday via text, I want to explain things a little further. So just a recap that yesterday 7/24/2018 we made contact with First Nation Health Chairman/CEO Matt Silverstein. We talked lengthy with him and he made sure to hear you out on all medical bill concerns/collection actions that are happening.

He stated that the TPO Network was not repricing claims correctly and this is holding up the review process for bills getting paid, which once that is configured those bills will be taken care.

I have sent you by email the Credit Dispute Letter to use against the collection agencies that are seeking you out for payment on medical bills. You need to use this letter template to protect your

EXHIBIT 4 tabbies

credit from any agency putting a bill collection on there. Make sure to fill out template with collection agency address and send it by certified mail with a return address.

Sage West medical bills- this has a Global Settlement that will be concluded in 30 days.

Guardian Flight- will be writing off the bill that you have been waiting for but now answers why you did not receive one. You will also receive a EOB (Explanation of Benefits) concerning this write off. -good news-

He did ask that I give you his personal cell phone number and you acknowledged that I did give that to you. He mentioned to call him directly if anything else is coming up with your medical bills.

I believe at this time since all efforts were made to make sure that you were heard on your concerns with the medical bills that I do not see that my emails need to be requested. If at anytime past the 30 days or if there is still a concern that you feel is not being fulfilled, please contact me as soon as possible.

Thank you!

"Compassion Is At The Heart Of Our Care"

Ina Weed-Hurley
Morning Star Care Center
Human Resource Specialist/Staff Development Coordinator

P.O. Box 859
Fort Washakie, WY. 82514
Phone: (307) 332-6902 Ext: 13
Fax: (307) 332-4279
inah@esthealth.org

EXHIBIT 5

VINCENT LAW
—OFFICE—

ATTORNEYS AT LAW
JOHN R. VINCENT
ADMITTED IN WYOMING & NEBRASKA
AARON J. VINCENT
ADMITTED IN WYOMING
ANN E. DAVEY
ADMITTED IN MONTANA & WYOMING
JANET E. MILLARD
ADMITTED IN WYOMING

WYOMING LEGAL ASSISTANT
CARLY J. SCHRINAR

MONTANA LEGAL ASSISTANT
JULIE D. HAMILTON

August 15, 2018

SENT VIA FACIMSILE TO:
(918) 514-6093

Matt Silverstein
Chief Executive Office
First Nation Health Insurance
10129 S. Yale Ave., Suite 300
Tulsa, OK 74137

Re: *Carley Clausen*

Dear Mr. Silverstein:

My name is Aaron J. Vincent. I am an attorney at Vincent Law Office in Riverton, Wyoming. I represent Ms. Clausen. It has come to my attention Ms. Clausen has experienced significant problems caused by First Nation Health Insurance Company's failure to pay for medical services. This failure has been ongoing for almost a year. I understand you and Ms. Clausen spoke on the phone wherein you stated and promised to have all outstanding medical bills resolved in Ms. Clausen's favor within thirty (30) days. That conversation took place on July 25, 2018.

So that we have a clear understanding, I want to make certain First Nation will keep its promise and pay Ms. Clausen's outstanding invoices on or about August 25, 2018. Should First Nation continue its failure to honor its contract and duties to its insured I will advise Ms. Clausen accordingly. Please also consider this letter request as a preservation letter, i.e. do not destroy any evidence, relevant or otherwise.

Thank you for your consideration. I look forward to First Nation resolving this matter promptly.

Sincerely,

Aaron J. Vincent

cc: Carley Clausen

EXHIBIT
tabbies
5

301 EAST ADAMS • PO BOX 433 • RIVERTON, WY 82501
307.857.6005 MAIN • 307.857.6192 FAX
INFO@JOHNVINCENTLAW.COM

621 E 4TH AVE N • PO BOX 1207 • COLUMBUS, MT 59019
406.322.8557 MAIN • 406.322.8599 FAX
WWW.JOHNVINCENTLAW.COM

EXHIBIT 6

LAW OFFICES
OF
FREESE & MARCH PA
ATTORNEYS AND COUNSELORS AT LAW

John M. Freese & Associates
John Markham Freese, Sr.
Charles H. March (Dec.)

Peachtree Square, Suite 113
4157 South Harvard Avenue
Tulsa, Oklahoma 74135-2606
Telephone: 918.749.9331
Facsimile: 918.749.9336
jfreese@freesemarch.com

August 27, 2018

Aaron Vincent, Esq.
Vincent Law Office
P.O. Box 433
Riverton, WY 82501

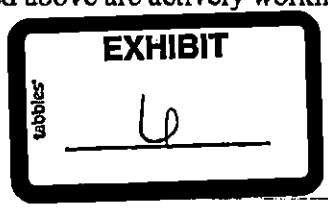
RE: Carley Clausen Letter

Dear Mr. Vincent:

We serve as counsel for FirstNation HealthCare. Your letter of August 15th has been referred to me for response.

FirstNation is not an insurance company; rather, they are consultants and fiduciaries to the Tribal government's sovereign self-funded plan. As a result, FirstNation can only disburse funds pursuant to the direction or authorization of the Tribe.

At this time there is a dispute between the Tribe and the PPO Network and FirstNation on the discount of the original billed charges For several providers, including some of Ms. Clausen's, First Health PPO Network was continuing to send the Tribe claims that were priced at an old discount and not as agreed. First, please be assured that FirstNation is working diligently with the indicated parties to resolve the issues and to expedite the crediting, processing and appropriate resolution of all claims including Ms. Clausen, which should have earlier occurred without delay or disruption. Some of Ms. Clausen's claims have reportedly already been processed and paid. After this week's check run, the only outstanding claims for Ms. Clausen will be the ones at SageWest and all parties described above are actively working to remedy the issues.



Simply stated, FirstNation was not the source of the problem and is trying diligently to resolve things in the best interest of the Tribe, tribal members and its employees.

We appreciate your patience and time. FirstNation will report to you and other interested parties as soon as possible on the resolution of the pending issues.

Cordially yours,

FREESE & MARCH

John M. Freese, Sr.

JMF/ts

EXHIBIT 7

Eastern Shoshone Business Council
P.O. Box 538
Fort Washakie, WY. 82514
(307) 332-3532/4912
Fax: (307) 332-7055

FOR IMMEDIATE RELEASE
December 21, 2018

Eastern Shoshone Tribe condemns SageWest, Apollo Global Management

Hospital system found to have charged tribe more than 700 percent profit margin

FORT WASHAKIE, WYOMING – After approximately a year of the tribe working in good faith to create a partnership with SageWest Healthcare, the tribe has determined the for-profit hospital rendered medical services to tribal members and employees – at both the Riverton and Lander locations – at profits that exceed 700 percent and include billing error rates consistently approaching 20 percent. The tribe condemned SageWest and Apollo Global Management today, issuing the following statement by Eastern Shoshone Business Council:

The Eastern Shoshone Tribe operates a highly efficient and advanced healthcare program that we have invested in that helps us understand what this hospital system has done and proposes to continue to do to our community. To be clear, a for-profit mutual fund giant, Apollo Global Management, has effectively acquired our community hospital as an asset which, according to their own press release, is now owned "by certain funds managed by affiliates of Apollo Global Management, LLC (NYSE: APO)."

We want to remind Apollo Global Management that Indian Country will not tolerate medical services being rendered to tribal communities and charging jaw-dropping rates that have allowed them to profit at an exorbitant and inappropriate rate. Furthermore, we do not believe the community or the nation is aware of these overcharges and systemic billing errors. The reimbursement rates profits for Medicare-participating providers are publicly available, we know what their facility charges are and we have requested itemized bills to identify the billing errors for the hospital. To date, SageWest and Apollo affiliates have actually had the audacity to state they will not "entertain" a discussion about their own billing errors. They claim to provide a fair and equitable arrangement for our people, but instead they have produced people who claim they do not have the proper authority to make decisions or they have stonewalled and circumvented direct talks completely.

Our health care costs are the tribe's second most expensive budget item. The lavish profits Apollo stockholders and executives stand to reap are at the expense of the health of tribal people. They have

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deployed various tactics to inflict fear in our community and they allege our tribe is being unreasonable, rather than their hospital which is extremely troubling. Meanwhile, this facility continues to operate the way we would expect an investment fund to operate. They have cut back on costs including quality of care to the point our people were tested for HIV/AIDS if they visited SageWest during a certain window, closed their newest location, announced the departure of a fairly new CEO and are overcharging us exponentially.

The tribe would also like to stress that tribal members and employees under the ShoshoneCare benefits plan are covered and they should ignore any demand for upfront payment to SageWest for emergency services, unless it is part of an out of pocket deductible. If tribal members or employees receive a bill, they should take it to their division human resources director so the issue can be addressed.

EXHIBIT 8

STATE OF WYOMING **COUNTY OF FREMONT**

ROCKY MOUNTAIN RECOVERY SYSTEMS, INC.

Plaintiff,

-vs-

CARLEY CLAUSEN

Defendant.

IN THE CIRCUIT COURT
NINTH JUDICIAL DISTRICT
1160 MAJOR AVE, STE 100

RIVERTON, WY 82501

Civil Action No._____

SUMMONS

TO THE ABOVE NAME DEFENDANT:

CARLEY CLAUSEN
816 CHERYL SUE DR
RIVERTON WY 82501
307-851-6708

POE: FREMONT COUNTY SCHOOL DIS
121 N 5TH ST W
RIVERTON, WY 82501
307-856-9407

YOU ARE HEREBY SUMMONED to file a written answer to the Plaintiff's complaint with the clerk of the above named court within 35 days after the complaint is filed with the court. The Complaint will be filed with the court within fourteen days of service and, upon filing, the Plaintiff will cause a notice of filing to be mailed to you at your last known address. You need not answer the Plaintiff's complaint if it is not filed within fourteen days after service. If the Complaint is timely filed and you fail to file your answer within the times stated herein judgment by default may be rendered against you.

DATED October 12, 2020.

By:_____
Bret T. Allred, 6-3835; Of counsel with
WILKERSON & WILKERSON, LLC
210 N Bent St., Powell, WY 82435-2336
Telephone: (307)754-8215
Toll Free: (888)226-7701
Attorneys for Plaintiff

(Service By: Wind River Investigation Inc.)

Plaintiff's File No. RMRSP.215274

EXHIBIT
tabbies
8

STATE OF WYOMING **COUNTY OF FREMONT**

ROCKY MOUNTAIN RECOVERY SYSTEMS, INC.

Plaintiff,

-vs-

CARLEY CLAUSEN

Defendant.

IN THE CIRCUIT COURT
NINTH JUDICIAL DISTRICT
1160 MAJOR AVE, STE 100

RIVERTON, WY 82501

Civil Action No._____

COMPLAINT

COMES NOW Plaintiff, by and through its undersigned firm of attorneys, **WILKERSON & WILKERSON, LLC**, and for its cause of action against Defendant, hereby states and alleges as follows:

1. The Plaintiff, is a corporation authorized to do business in the State of Wyoming with its principal place of business in Gillette, Wyoming.

2. That venue and jurisdiction are proper in this County as the obligation was incurred in the county or Defendant currently resides in the county.

3. That Defendant is liable on the following obligation, said obligation being past due and payable and assigned by Creditor to Plaintiff for collection, to wit:

CREDITOR	AMOUNT	INTEREST	FEES	TOTAL
CASPER SURGICAL CENTER	17257.12	3468.44	304.00	21029.56
TOTAL	17257.12	3468.44	304.00	21029.56

4. That Plaintiff has made demand upon Defendant for payment of the above listed obligation, but Defendant has failed to pay the amount due.

5. That Plaintiff has been required to hire an attorney and expend monies in costs and attorney fees in order to collect the amount owed by Defendant and Defendant should be required to pay to Plaintiff its costs and reasonable attorney fees as may be allowed by law.

WHEREFORE, Plaintiff demands judgment against Defendant as follows:

1.	Indebtedness of	$ 17257.12
2.	Plus interest to date of	3468.44
3.	Plus attorney fees to date of	189.00
4.	Plus court costs and process service fees of	115.00

for a total due to date of **$ 21029.56**, together with interest, attorney fees and other costs as may accrue hereafter and be allowed by law, and for such other and further relief as the court may deem just and proper.

DATED October 12, 2020.

By: _____

Bret T. Allred, 6-3835; Of counsel with
WILKERSON & WILKERSON, LLC
210 N Bent St., Powell, WY 82435-2336
Telephone: (307)754-8215
Toll Free: (888)226-7701
Attorneys for Plaintiff

EXHIBIT 9

816 Cheryl Sue
Riverton, WY 82501

November 7, 2019

VIA CERTIFIED MAIL

Pamela Eagle Hawk or Current Plan Administrator
Eastern Shoshone Tribe Employee Benefits Plan
15 North Fork Road
Fort Washakie, WY 82514

FirstNation Health Care, LLC
10129 S. Yale Ave., Suite 300
Tulsa, OK 74137

Dear Plan Administrators/Third Party Administrators:

I was employed at Morning Star Care Manor, Fort Washakie, WY from August 20, 2013, through May 22, 2018. As an employee, I paid for, and received, health care coverage pursuant to the Eastern Shoshone Health Care Plan.

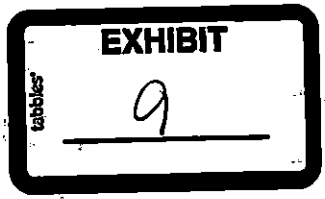
The original plan document I was given is dated 12/8/2012. I have an additional plan document from August, 2014. Pursuant to the provisions contained in these documents and the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), I request copies of the following materials:

1. The Plan document which governed health care coverage for Eastern Shoshone Tribal employees at Morning Star Care Manor for the Plan years 2016 and 2017;

2. All plan documents and insurance contracts and related documents governing and relating to my health care coverage as an employee at Morning Star Care Manor for the years 2016, 2017 and 2018. By this separate request, I am seeking those documents which are not encompassed in the immediately preceding request;

3. All Administrative Services Agreement(s) and all other contracts between the Eastern Shoshone Tribe ("EST") and FirstNation Health Care, LLC ("FirstNation") for the years 2016, 2017 and 2018;

4. All Administrative Services Agreement(s) and all other contracts between EST and FirstNation, including agreements as to claims fiduciary obligations, relating to health care coverage provided by the EST to its employees for the years 2016, 2017 and 2018;



5. Any and all other contracts including, but not limited to: Insurance and Reinsurance contracts, Stop Loss Contracts, Insurance Intermediary Services Contracts, Health Plan contracts, including PPO and POS agreements and Administrative Services Contracts related to the Eastern Shoshone Health Plan or coverage provided by the EST;

6. Any other Plan documents, Amendments to the Plan Documents for the EST Health Plan, including but not limited to, the Summary Plan Descriptions for the years 2016, 2017 and 2018;

7. Any Summary of Material Modifications statements for the EST Health Plan for the years 2016, 2017 and 2018;

8. Summary Annual Report statements, if any exist, for the EST's Health Plan for the years 2016, 2017 and 2018;

9. Form 5500, including all attached schedules, filed with the U.S. Department of Labor for the years 2016, 2017 and 2018 for the EST's Health Plan.

Please forward these materials to my attorney: Aaron Vincent, Vincent Law Office, 301 East Adams, Riverton, WY 82501. If you wish to provide these documents by email as "pdf files," address them to aaron@johnvincentlaw.com.

Thank you.

Carley Clausen

Carley Clausen, Plan Beneficiary

EXHIBIT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

First Nation Health Care, LLC
10129 S. Yale Ave., Suite 300
Tulsa, OK 74137

9590 9402 4933 9063 7374 91

2. Article Number (Transfer from service label)
7019 0700 0000 4473 4466

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Kathy Phillips ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Pamela Eagle Hawk or Current Plan Administrator
EST Employee Benefits
P.O. Box 538
Fort Washakie, WY 82514

9590 9402 4933 9063 7374 46

2. Article Number (Transfer from service label)
7019 0700 0000 4473 4473

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
11/13/19

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☑ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

EXHIBIT
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U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®.
TULSA, OK 74137
OFFICIAL USE

Certified Mail Fee	$3.50
Extra Services & Fees (check box, add fee as appropriate)	$2.80
☐ Return Receipt (hardcopy)	$0.00
☐ Return Receipt (electronic)	$0.00
☐ Certified Mail Restricted Delivery	$0.00
☐ Adult Signature Required	$0.00
☐ Adult Signature Restricted Delivery	$
Postage	$0.55
Total Postage and Fees	$6.85

0496 11
Postmark Here
NOV 12 2019
11/12/2019

Sent To: First Nation Health Care, LLC
Street and Apt. No., or PO Box No.: 10129 S. Yale Ave., Suite 300
City, State, ZIP+4®: Tulsa, OK 74137

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7019 0700 0000 4473 4466

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®.
FORT WASHAKIE, WY 82514
OFFICIAL USE

Certified Mail Fee	$3.50
Extra Services & Fees (check box, add fee as appropriate)	$2.80
☐ Return Receipt (hardcopy)	$0.00
☐ Return Receipt (electronic)	$0.00
☐ Certified Mail Restricted Delivery	$0.00
☐ Adult Signature Required	$0.00
☐ Adult Signature Restricted Delivery	$
Postage	$0.55
Total Postage and Fees	$6.85

0496 11
Postmark Here
RIVERTON WY 82501
NOV 13 2019
11/13/2019
USPS

Sent To: EST Employee Benefits
Street and Apt. No., or PO Box No.: P.O. Box 538
City, State, ZIP+4®: Fort Washakie, WY 82514

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7019 0700 0000 4473 4473